DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706


**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

May 21, 2018

Pankaj Bhanot
Director, Department of Human Services
P.O. Box 339
Honolulu, HI 96809-0339

Dear Mr. Bhanot:

I am pleased to inform you that your request to amend the Hawaii Section 1915(c) Home and Community-Based Services for People with Intellectual and Developmental Disabilities (I/DD) waiver has been approved. The amendment has been assigned Control Number 0013.R07.02 and is approved with a June 01, 2018 effective date.

This amendment makes significant updates to the waiver including the following: phases out skilled nursing as a waiver service; adds private duty nursing; implements supports budgets to enable beneficiaries to have choice and flexibility in their services; expands the eligibility groups to include blind or disabled individuals under §1634(c) of the Act; and revises service specifications and rates for other existing services. The following services are offered through the I/DD waiver: adult day health, discovery & career planning, individual employment supports, personal assistance/habilitation, respite, private duty nursing, additional residential supports, assistive technology, chore, community learning services, environmental accessibility adaptations, non-medical transportation, personal emergency response system, specialized medical equipment and supplies, training and consultation, vehicular modifications, and waiver emergency services.

We appreciate the cooperation of your staff during the amendment review process. If you or your staff have questions about this waiver amendment, please contact Adrienne Hall at (415) 744-3674 or by email at Adrienne.Hall@cms.hhs.gov.

Sincerely,

/s/

Hye Sun Lee
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Judy Mohr Peterson, Department of Human Services (DHS) Medi-QUEST Division
Aileen Manuel, Department of Human Services (DHS) Medi-QUEST Division

# Application for a §1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information

**A.** The **State** of **Hawaii** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

**B. Program Title:**
**HCB Services for People with Intellectual and Developmental Disabilities (I/DD Waiver)**

**C. Waiver Number:HI.0013**
**Original Base Waiver Number: HI.0013.**

**D. Amendment Number:HI.0013.R07.02**

**E. Proposed Effective Date:** *(mm/dd/yy)*
06/01/18

**Approved Effective Date: 06/01/18**
**Approved Effective Date of Waiver being Amended: 07/01/16**

### 2. Purpose(s) of Amendment

**Purpose(s) of the Amendment.** Describe the purpose(s) of the amendment:
This is a technical amendment to address items that were not included in the waiver renewal approved effective July 1, 2016 and the amendment approved effective June 1, 2017. This amendment will add services mixes and supports budgets to enable participants to have choice, flexibility and control over their services. The amendment also adds a new service, phases-out one service and clarifies language in several services. Changes to the approved waiver that are being made in this amendment include:

1) Service Mix and Supports Budget – Phase-in Supports Budgets enables participants to receive a prospective budget that reflects their needs and empowers them to make decisions about how to use their budget to access the supports that best meet their unique circumstances. Support Budgets are based on the participant's level of support needs and the type of setting where the participant resides. Participants are assigned to one of seven support 'levels' based on the Supports Intensity Scale for Adults (SIS-A™). There are three types of settings – living in licensed or certified setting, living in a family setting, and living in own home. The following services are subject to the Supports Budget:

- Adult Day Health
- Community Learning Service – Group
- Community Learning Service - Individual
- Personal Assistance/Habilitation (not applicable for participants in licensed or certified settings)

- Chore (not applicable for participants in licensed or certified settings)
- Respite (only applicable for participants living in a family home)

All other services may be authorized in addition to the limit established by a participant's Supports Budget.

2) Add a new service – Private Duty Nursing (PDN). Based on a case-by-case analysis of every participant with complex medical needs who receives Skilled Nursing and also benefits from the habilitative services of the Medicaid I/DD Waiver, PDN will align best with participants' needs for continuous ongoing nursing support.

3) Phase out an existing service – Skilled Nursing. Skilled Nursing will phase out as participants are transitioned to the supports that best meet their needs, e.g., transition to waiver services such as PDN or Respite provided by a nurse or State Plan/Long Term Supports and Services (LTSS) through the QUEST Integration health plans. Skilled Nursing will sunset during state fiscal year 2019 (by 6/30/2019).

4) Revise Service Specifications for existing services – Six (6) services will be modified (Adult Day Health, Assistive Technology, Community Learning Services, Environmental Accessibility Adaptations, Personal Assistance/Habilitation and Vehicular Modifications).

- Adult Day Health: Remove language for participants of retirement age because all ADH services will be 15 minute units by the end of Waiver Year 2 (by June 30, 2018) and the language was pertinent only to the half-day/full-day units. Language was removed that identified activities in the community that are included in Community Learning Services. The exception process to the limit of 1560 combined hours of ADH and CLS-Group was added. The exception process was included in the Amendment 01 in Attachment #1: Transition Plan; however, it was not repeated in the service definition for ADH.

- Assistive Technology: Removed duplicative language in service description. Added "programming" to the list of tasks that are included with the service. This change is based on stakeholder input that some technology devices require programming to make the device or software operational by the participant.

- Community Learning Services (CLS): Based on stakeholder input, language is added to clarify how children under 21 can use CLS services. Language is also added to require an employment job coach, at least annually, to assess the ongoing need for CLS staff to support a participant on the job. Language was added to describe how CLS may be used with children. The exception process to the limit of 1560 combined hours of ADH and CLS-Group was added. The exception process was included in the Amendment 01 in Attachment #1: Transition Plan; however, it was not repeated in the service definition for CLS.

- Environmental Accessibility Adaptations (EAA): Clarify the exclusion of "additional square footage" to enable stakeholders to understand what is covered under the waiver and what would require funding outside the waiver; add language that converting cesspools is excluded.

- Vehicular Modifications: Add coverage for repairs to the adaptive equipment installed in the vehicle (e.g., lift, tie-down/locking system, etc.) which allows for the most cost-effective method to ensure a safe, operational lift system for the vehicle.

5) Revise Provider Qualifications – Respite. Add Registered Nurse (RN) and Licensed Practical Nurse (LPN) as qualified staff employed by the I/DD Waiver Provider Agencies to deliver Respite. This will enable waiver participants of all ages who have complex medical needs that cannot be delegated, live with family, and receive Respite from a nurse.

6) Expand eligibility groups in Appendix B-5-b to include blind or disabled individuals under section 1634(c) of the Act.

7) Update language in Appendix D-1-d to reflect the phase-in of Service Mix and Supports Budget.

8) Clarify language in Appendix E-1-f that enables a legal guardian to assist a participant to choose a non-legal representative to serve as the consumer directed employer on behalf of the participant.

9) Add a function for the Financial Management Service in Appendix E-1-i to process and pay invoices for goods and services approved in the service plan.

10) In Appendix J, increase unit cost for Non-Medical Transportation from $2.00 per trip to $6.00 per trip. This change is

needed to address fee changes for public and paratransit services which range from $2.00 on most islands to $6.00 on the Big Island. This increase will help support participants to engage in activities in their communities.

11) In Appendix J, increase rates for Training & Consultation - Behavior Analysis; increase rates for Registered Behavior Technicians delivering Personal Assistance/Habilitation (PAB), Adult Day Health (ADH) and Community Learning Services (CLS); add new rates for Private Duty Nursing by a Registered Nurse (RN) and Licensed Practical Nurse (LPN); add new rates for Respite by a RN or LPN.

## 3. Nature of the Amendment

**A. Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

| Component of the Approved Waiver | Subsection(s) |
|---|---|
| ☑ **Waiver Application** | |
| ☑ **Appendix A – Waiver Administration and Operation** | |
| ☑ **Appendix B – Participant Access and Eligibility** | B-5 |
| ☑ **Appendix C – Participant Services** | C-1/C-3, C-4 |
| ☑ **Appendix D – Participant Centered Service Planning and Delivery** | D-1 |
| ☑ **Appendix E – Participant Direction of Services** | E-1 |
| ☐ **Appendix F – Participant Rights** | |
| ☐ **Appendix G – Participant Safeguards** | |
| ☐ **Appendix H** | |
| ☑ **Appendix I – Financial Accountability** | I-2 |
| ☑ **Appendix J – Cost-Neutrality Demonstration** | J-2 |

**B. Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☑ **Modify Medicaid eligibility**
- ☑ **Add/delete services**
- ☑ **Revise service specifications**
- ☑ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☑ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

  Specify:
  Add service mixes and supports budgets

# Application for a §1915(c) Home and Community-Based Services Waiver

## 1. Request Information (1 of 3)

**A.** The **State** of **Hawaii** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

**B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):
**HCB Services for People with Intellectual and Developmental Disabilities (I/DD Waiver)**

**C. Type of Request: amendment**

**Requested Approval Period:***(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

**Original Base Waiver Number: HI.0013**
**Waiver Number:HI.0013.R07.02**
**Draft ID: HI.001.07.02**

**D. Type of Waiver** *(select only one):*

Regular Waiver

**E. Proposed Effective Date of Waiver being Amended: 07/01/16**
**Approved Effective Date of Waiver being Amended: 07/01/16**

## 1. Request Information (2 of 3)

**F. Level(s) of Care**. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

## 1. Request Information (3 of 3)

**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

**Specify the §1915(b) authorities under which this program operates** *(check each that applies):*

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

**H. Dual Eligiblity for Medicaid and Medicare.**

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## 2. Brief Waiver Description

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Purpose:

To enable persons with intellectual and developmental disabilities (I/DD) who meet institutional level of care the choice to live in their homes and communities with appropriate quality supports designed to promote health, community integration, safety and independence.

Goals/Objectives:

1) To provide necessary supports to participants in the waiver to have full lives in their communities and to maximize independence, autonomy and self-advocacy.

2) To evaluate and continuously improve the quality of services to participants, including measuring the satisfaction of the benefits and services the participants receive, in order to improve them.

Organizational Structure:

Department of Human Services, Med-QUEST Division (DHS/MQD) is the Single State Agency/Medicaid agency and the Department of Health, Developmental Disabilities Division (DOH/DDD) operates the waiver. DHS/MQD and DOH/DDD have a Memorandum of Agreement (MOA) to administer, operate, and monitor the program. The MOA defines the roles and responsibilities required by each state department for waiver operation and administration.

Authority:

The waiver will be implemented by the DOH/DDD under the supervision and delegation of the DHS/MQD. DHS/MQD exercises oversight and ultimate approval over DOH/DDD's implementation, administration and operation of the waiver program. DHS/MQD promulgates rules regarding the oversight and operational approval authority that are binding upon DOH/DDD. DHS/MQD retains ultimate responsibility for the waiver. DHS/MQD serves as the primary communication liaison with CMS and directly involves DOH/DDD in discussions pertinent to the waiver.

DOH/DDD is the State agency responsible for administering programs for individuals with intellectual and developmental disabilities. DOH/DDD issues policies, rules, and regulations regarding the implementation, administration and operation of the waiver program, under the supervision and approval of DHS/MQD. DOH/DDD consults with and collaborates with DHS/MQD on all matters pertinent to waiver operations.

Waiver services are primarily delivered through agencies that enter into Medicaid Provider Service Agreements with

DHS/MQD. For certain services, participants may select and direct their services through the consumer directed option. Service providers may provide one or more services as described in Appendix C.

## 3. Components of the Waiver Request

**The waiver application consists of the following components.** *Note: Item 3-E must be completed.*

**A. Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

**B. Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

**C. Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

**D. Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

**E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

**F. Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

**G. Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

**H. Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

**I. Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

**J. Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

## 4. Waiver(s) Requested

**A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

**B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

**C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

**In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:**

**A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

**B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

**C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

**D.** Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

**E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would

have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

**F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

**G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

**H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

**I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

**J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

***Note: Item 6-I must be completed.***

**A. Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

**B. Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

**C. Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

**D. Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

**E. Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

**F. FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or

as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

**G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

**H. Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

**I. Public Input.** Describe how the State secures public input into the development of the waiver:
WAIVER AMENDMENT 02 (submitted February 2018):

During November and December 2018, prior to the formal public input process that began on December 18, 2017, DHS/MQD and DOH/DDD conducted ten (10) public information sessions to explain the proposed changes to the waiver. Nine (9) sessions were held in-person on Oahu (West, East and Windward) and neighbor islands (Hawaii – Hilo, Hawaii - Kona, Maui and Kauai). One session was held via teleconference with stakeholders on Molokai. A total of 304 individuals attended the public information sessions. DHS/MQD and DOH/DDD met regularly with several organizations to obtain comment and input prior to and during the formal 30-day public notice and comment period, including the Waiver Policy Advisory Committee (Waiver PAC), Self-Advocacy Advisory Council (SAAC), the Hawaii State Council on Developmental Disabilities, and the Hawaii Waiver Provider Association (HWPA).

The tribal notice was mailed to Ke Ola Mamo on December 18, 2017. Also on December 18, 2017, the public notice was provided in a newspaper publication and posted on the DHS/MQD website humanservices.hawaii.gov/mqd/ and the DOH/DDD website health.hawaii.gov/ddd. Letters were mailed to each participant and their families that summarized the proposed changes in the amendment application and how to provide input (email, fax, phone, mail). Copies of the entire waiver application were available to participants and families via the website, several offices of DHS/MQD and DOH/DDD and through their case managers upon request. All providers received an email with the same information.

In compliance with federal requirements for a minimum of 30 days for public input, interested members of the public were given 45 days to submit written comments through February 2, 2018. The tribal consultation ended on February 2, 2018.

In total, 43 written comments were received from 11 organizations and individuals. There were no comments from Ke Ola Mamo. Comments received were thoughtfully written and constructive. DHS/MQD and DOH/DDD appreciate all those who took time to provide feedback. Three (3) changes were made to the waiver amendment as a result of the feedback received. The complete public comment summary will be posted on the DHS/MQD website at humanservices.hawaii.gov/mqd/ and the DOH/DDD website at health.hawaii.gov/ddd/. The summary of public comments that resulted in changes to the amendment application are in the Additional Needed Information Section (Optional) of this application.

**J. Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:** Mohr Peterson

**First Name:** Judy

**Title:** Med-QUEST Division Administrator

**Agency:** Department of Human Services

**Address:** 601 Kamokila Boulevard, Suite 518

**Address 2:**

**City:** Kapolei

**State:** **Hawaii**

**Zip:** 96709

**Phone:** (808) 692-8050 **Ext:** ☐ **TTY**

**Fax:** (808) 692-8155

**E-mail:** JMohrPeterson@dhs.hawaii.gov

**B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:** Brogan

**First Name:** Mary

**Title:** Administrator, Developmental Disabilities Division

**Agency:** Department of Health

**Address:** 1250 Punchbowl Street, Room 463

**Address 2:**

**City:** Honolulu

**State:** **Hawaii**

**Zip:** 96813

**Phone:** (808) 586-5840 **Ext:** ☐ **TTY**

**Fax:** (808) 586-5844

**E-mail:** mary.brogan@doh.hawaii.gov

## 8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

**Signature:** Aileen Manuel

State Medicaid Director or Designee

**Submission Date:** May 16, 2018

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

**Last Name:** Bhanot

**First Name:** Pankaj

**Title:** Director

**Agency:** Department of Human Services

**Address:** 1390 Miller Street, Room 209

**Address 2:**

**City:**

Honolulu

**State:** **Hawaii**

**Zip:**

96813

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(808) 586-4993 **Ext:** ☐ **TTY**

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(808) 586-4890

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dhs@dhs.hawaii.gov

## Attachments

**Attachment #1: Transition Plan**

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☑ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☑ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☑ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☑ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

SUPPORTS BUDGETS:
During Year 3 of the waiver renewal (state fiscal year 2019), DOH/DDD will phase-in the use of the Supports Budget, with a plan to transition all participants age 18 years and older by the end of the current waiver (by June 30, 2021). Participants will transition at their annual ISP year based on the phase-in schedule. The phase-in schedule is as follows:
- Cohort 1 includes participants living in licensed or certified settings and will transition to the Supports Budget during state fiscal year 2019 (beginning July 1, 2018).
- Cohort 2 includes participants living in other settings (either family or own home) and receiving Adult Day Health services. Cohort 2 will transition to the Supports Budget during state fiscal year 2020 (beginning July 1, 2019).
- Cohort 3 includes participants living independently or in family homes and not receiving Adult Day Health services. Participants will transition to the Supports Budget during state fiscal year 2021 (beginning July 1, 2020).
Children under age 18 years are not subject to the Supports Budget. Services for children continue to be determined through the ISP using the current process for authorizing services.
This phased-in approach has been adopted for three primary reasons.
1) It follows the same cohorts that are in a current three-year phase-in for the new services and rates approved in Waiver Amendment 01 and the SIS must be competed to determine the Supports Budget. DOH/DDD will complete the assessments for the entire population by the end of Waiver Year 4 (by June 30, 2020).
2) This approach allows the cost increases to the State to be spread over several years rather than requiring that the full cost of implementation be funded immediately.
3) It allows for analysis of trends and exceptions data to make adjustments as needed.
DOH/DDD is committed to working with participants, families, providers and other stakeholders and has developed detailed operational plans to ensure a successful transition.

The State's process for establishing supports budgets was designed to minimize the number of participants who will potentially receive fewer services and to protect the health and safety of those may experience a reduction. The Individual

Supports Budgets are intended to align access to services with participants' needs. To assess needs, the State selected the Supports Intensity Scale (SIS), a normed and validated instrument established specifically for the I/DD population by the American Association on Intellectual and Developmental Disabilities (AAIDD) and used by more than 20 states. Assessments are administered by staff who have received training and interrater reliability testing from AAIDD. With the assistance of the non-profit Human Services Research Institute (HSRI), the State adopted a framework used by several other states to assign individuals to one of seven levels of need.

The Individual Supports Budgets are based on 'model' service mixes that reflect the types and amounts of supports necessary to meet the needs of participants based on their assessed needs and residential placement. Initial services mixes were created by interdisciplinary team that considered the typical needs of individuals in each group and current utilization patterns. The initial service mixes were then subject to a validation process. The State compiled approximately 100 case files that underwent a structured review process by several teams comprised of State staff as well as representatives from the Hawaii's UCEDD and DD Council and a parent. For each case reviewed, the teams were asked to determine whether the Individual Supports Budget that the participant would receive would be sufficient to meet their needs. Based on this validation process, minor changes were made to the initial service mixes.

The State believes that the use of a rigorous and objective assessment and the thorough process to develop the Individual Supports Budgets has produced a framework that assures the health and welfare of waiver participants. An analysis of current utilization found that the Individual Supports Budgets were greater than current service usage for approximately 86 percent of participants.

Although the State believes that Individual Supports Budgets are sufficient, there will be a comprehensive process for participants to request additional services. If a participant needs a greater budget due to a change in condition since their previous SIS assessment, they may receive a new assessment. New assessments are limited to documented changes in condition or instances in which the original assessment was not conducted in accordance with State policies.

To ensure sufficient notice of potential changes, individuals will be transitioned to their Individual Supports Budget as part of their annual planning process (that is, the State is not proposing to terminate, suspend, or reduce existing authorizations). Participants and their circle of support will be informed of their Individual Supports Budgets prior to their annual planning meeting. If a participant and their family/guardian believes that the services are insufficient to meet their needs, the case manager will discuss alternatives. For example, individuals may choose lower-cost group services to 'stretch' their budgets or residential habilitation may be discussed with those who require significant supports. If the alternatives presented in the annual planning meeting are not accepted by the participant and their family/guardian, they can request an exception. As noted in Appendix C-4, the State may grant exceptions for several reasons, including the health and safety of the participant. Continuous monitoring of health and safety a described in Appendix G is in effect. Finally, if the State denies requested services in whole or in part due to the limits established by Individual Supports Budgets, the participant will be informed of their right to appeal and request a fair hearing, consistent with the requirements of 42 C.F.R. 431.200 et seq.

REVISE NURSING SERVICES TO ADD PRIVATE DUTY NURSING, PHASE-OUT SKILLED NURSING, ADD NURSES TO RESPITE SERVICES

These changes were identified through regular discussions between DHS/MQD and DOH/DDD, medical directors and nurse consultants.

Skilled Nursing, Private Duty Nursing and Nursing Respite are each provided by a registered nurse or licensed practical nurse working under the supervision of the RN. The RN and LPN must be licensed in the State of Hawaii and must possess the skills required within their scope of practice.

The services differ in terms of duration and focus:

- Skilled Nursing in the waiver is an extended State Plan service which is delivered in a manner that is episodic, intermittent, and part-time as described in the Technical Guide. It is not designed to meet ongoing, continuous needs for an individual with chronic health conditions.
- Private Duty Nursing covers longer duration, continuous, ongoing services for adult waiver participants with chronic medical conditions who need a nurse to deliver services that cannot be delegated to a direct support worker. Examples are tracheostomy care, deep suctioning, and activities that require a nurse's experience, clinical judgement and education to intervene on an ongoing basis. For children aging off EPSDT, the waiver does not currently have an equivalent service to EPSDT PDN, which is needed to assure continued health and welfare at age 21 and older.
- Similar to PDN, Nursing Respite covers longer duration, continuous, ongoing services for participants with chronic medical conditions who need a nurse to deliver services that cannot be delegated to a direct support worker. While the waiver could consider use PDN for respite-type care for adult participants, PDN is not available to children and Respite is not an EPSDT service. The addition of nurses as qualified providers of Respite will ensure health and welfare for waiver participants of all ages who require a nurse to deliver services while providing respite to families when needed.

DHS/MQD and DOH/DDD analyzed case review data of every participant who currently receives Skilled Nursing. In general, four groups were identified:

1) Participants whose needs could best be met using State Plan nursing services rather than Skilled Nursing waiver services.
2) Participants whose needs are primarily medical and who meet both the level of care for nursing facility and for ICF/IID

and who may choose to receive Long Term Supports and Services (LTSS) from the QUEST Integration health plans. DOH/DDD conducted a comprehensive review beginning in the Fall of 2017 and identified five adults who will transition to the QUEST Integration health plan for long-term supports and services (LTSS) and be disenrolled from the waiver entirely. These individuals currently receive skilled nursing and personal care, but have no other habilitative waiver services. As of 4/15/2018, these data are still current. All five individuals live with family or in their own home, so there is no disruption of placement. These five individuals will access nursing and personal care services as LTSS under QUEST Integration through the health plans. DHS/MQD will oversee the transitions for these participants to assure health and welfare.
3) Participants whose complex medical needs would be better met through continuous, ongoing nursing services, while also benefiting from habilitative services in the I/DD waiver.
4) Participants living with family who need nursing services for complex medical needs that cannot be delegated and could benefit from Respite provided by a nurse when the family needs relief.
A team of representatives from DHS/MQD and DOH/DDD will coordinate the transition for each waiver participant currently receiving Skilled Nursing as an extended State Plan service in the I/DD waiver. This transition will be coordinated on a case-by-case basis to ensure a smooth transition either to LTSS in the QUEST Integration plan or to other waiver services that meet the participant's nursing needs. This Transition team meets at least monthly and has been working together for several years. The team is led by the DHS/MQD Medical Director and includes registered nurses, socials workers, and waiver program staff. The Medical Director will assign a lead agency and staff to oversee and manage each participant's transition. The Transition team will work closely with each participant, family, case manager and others in the participant's circle of support to ensure an individualized plan that meets the participant's health and welfare. The amount/scope of services will be discussed with the participant, parent and/or legal representative at an Individualized Service Plan (ISP) meeting. If the participant believes the amount/scope of services being recommended for the transition is not sufficient to meet his/her needs, the participant and legal representative will be provided with a Notice of Action informing of their right to appeal and request a fair hearing, consistent with the requirements of 42 C.F.R. 431.200 et seq.

ALL OTHER CHANGES
Other changes proposed in this amendment may increase access to services, but are not anticipated to decrease any services. Whenever a waiver service is suspended, reduced or terminated, the DOH/DDD case manager completes a Notice of Action (NOA) form to inform the participant of the adverse action and the reason for the action. The Notice of Action form is provided at least ten (10) working days prior to the action being taken, per Hawaii Administrative Rules (HAR)§ 11-88.1-10 (b) except in circumstances as defined in HAR §17-l 713(1)(c) where adequate notice shall be sent not later than the date of the action. A copy of the Notice of Action form is kept in the participant's case file. The NOA states the adverse action and the right to appeal to DOH/DDD and DHS/MQD.

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*
*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*
*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*
*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

Hawaii assures that the settings transition plan included with this amendment will be subject to any provisions or requirements included in Hawaii's approved Statewide Transition Plan. Hawaii will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

HAWAII'S STATEWIDE TRANSITION PLAN

SUMMARY OF THE CMS HOME AND COMMUNITY BASED FINAL RULE
In January 2014, the Centers for Medicare & Medicaid Services (CMS) issued new regulations that require home and community-based waiver services to be provided in community like settings. See www.medicaid.gov and search for home and community based services for a copy of the regulations. The new rules define settings that are not community-like and after a transition period, those settings that do not meet the new rules cannot be used to provide federally-funded home and community based services (HCBS). The purpose of these rules is to ensure that people who receive home and community-based waiver services have opportunities to access the benefits of community living and receive services in the most integrated settings. States will be allowed a maximum of five years (until March 2019) to make the transition. Hawaii intends to implement its transition plan by July 2017. The requirements for submitting a transition plan to CMS rest with the single-state Medicaid agency. In Hawaii, the Department of Human Services, Med-QUEST Division (DHS/MQD) has taken the lead for meeting the requirements for the transition plan. Hawaii proposes the My Choice My Way transition plan with the following time table and deliverables to come into compliance with CMS' revised HCBS rules.

HAWAII'S MY CHOICE MY WAY ADVISORY GROUP
Hawaii's transition plan is called "My Choice My Way." DHS/MQD convened an advisory group called My Choice My Way to develop Hawaii's transition plan. Self-Advocacy Advisory Council (SAAC participates on the My Choice My Way advisory group. At the formation of the group, SAAC chose the name, My Choice My Way, for the transition plan and advisory group.

The Department of Human Services, Med- QUEST Division (DHS/MQD) is partnering with various organizations in Hawaii that includes SAAC, Special Parent Information Network (SPIN), Department of Health, Developmental Disabilities Division (DOH/DDD), Department of Health, Office of Health Care Assurance (DOH/OHCA), State Council on Developmental Disabilities (DD Council), Case Management Agencies, Hawaii Waiver Provider Association (HWPA), Adult Foster Homes of the Pacific, and Big Island Adult Foster Home Operators. These organizations represent Medicaid waiver participants, waiver families, provider associations, advocates, other State agencies, and other stakeholders throughout this process to develop the plan, receive input, and assure that everyone has access to needed information to assist with transition activities. The organizational structure for the My Choice My Way advisory group is below.

The DHS/MQD is committed to engaging with stakeholders through this process and looks forward to continuing to receive feedback. The outcome of this process will be that Medicaid waiver participants will receive services in a way that enables them to live and thrive in truly integrated community settings.

The My Choice My Way advisory group had its first meeting in October 2014. This advisory group has met at least monthly to develop the transition plan, review the public comments, and incorporate public comments into the transition plan. The My Choice My Way advisory group will continue to meet for implementation of the transition plan.

COMPONENTS OF THE MY CHOICE MY WAY TRANSITION PLAN
1. ASSESSMENT (both residential and non-residential settings)
Process for assessing and analyzing all HCBS settings for compliance
Individuals who have access to HCBS will have an opportunity to participate in assessing their settings
The assessment may be completed alone or with help from family/friends
Case managers and service coordinator may help complete assessment as well
Providers will be given an opportunity for self-assessment of their settings
State agencies perform an analysis of both individual and provider assessments
State agencies perform mandatory site validation visits for providers setting that may isolate
Update transition plan based upon assessments

2. REMEDIATION
Modify State Statutes, Rules, Standards, or Other Requirements to meet new HCBS rules
Inform providers of room for improvement to meet rules based upon assessments
State agencies submit justification for heightened scrutiny to CMS for settings that may isolate but are in fact HCBS and do not have the qualities of an institution
Develop operational procedures with providers to implement changes to meet new HCBS rules
Develop relocation plan for individuals that are in a setting that does not meet the new HCBS rules

3. KEY STAKEHOLDER ENGAGEMENT AND PUBLIC COMMENT
Posted a public notices and conducted comment periods- December 16, 2014 to January 30, 2015 and January 15, 2016 to March 1, 2016
Sent tribal consultation letters with draft transition plan to Ke Ola Mamo- For December 12, 2014 and December 30, 2015-

Ke Ola Mamo did not provide comments on the transition plan to DHS/MQD for the first and second public comment period
Public Forums held at the Queen's Conference Center Auditorium and streamed live through video teleconference (VTC) sites on neighboring islands- January 14, 2015 and January 14, 2016
Informational session held twice a year in January and July: one session will be for participants, families, advocates and the other for providers.

LOCATION OF THE MY CHOICE MY WAY TRANSITION PLAN
On the Med-QUEST website at www.med-quest.us  News and Events section

SUMMARY OF PUBLIC COMMENTS
DHS/MQD received public comment from two public forums as well as through its formal public comment period. Attached is a copy of the newsletter that DHS/MQD posted on its website for the public forums. In addition, several organizations from the My Choice My Way advisory group distributed to their membership information about the forum to include SPIN, HWPA, DOH/DDD, DHS/MQD, and Case Management Agencies. DHS/MQD has copies of all of the public comments that we received for submission to CMS, if indicated. In addition, below is a summary of the public comments that DHS/MQD received since publishing its draft My Choice My Way transition plan as well as changes that DHS/MQD made to the transition plan based upon public comment. A table summary provides information on the comment type, date received, comment summary, state response, and impact on transition plan.

PUBLIC FORUMS
January 14, 2015 and January 14, 2016
Approximately 200 individuals statewide attended the public forum to include in person and video teleconference (VTC) sites on the following islands: Hawai'i (one in Hilo and one in Kona), Kaua'i, Maui, Moloka'i, O'ahu (one in person and one VTC). The attendees included waiver participants, their families, providers to individuals receiving HCBS, state agencies that provide services to waiver participants, and other stakeholders The first forum provided an overview of the HCBS rules and a summary of the draft transition plan. The forum provided an overview site validation visits. Attached is a copy of the presentation of the public forum. Afterwards the My Choice My Way advisory group (or panelists) answered questions from the attendees. For questions that were related to the transition plan, the panelists referred individuals to components of the My Choice My Way transition plan (i.e., process for assessments). Both events were moderated by Hilopa'a, Hawaii's Family to Family Health Information Center. Many of the questions in the first forum were not related to the My Choice My Way transition plan. The second forum provided a summary of updates on the transition plan and shared assessment results from validations.

PUBLIC COMMENTS
January 14, 2015 and January 14, 2016
DHS/MQD received public input from the first public forum as well as four written comments: one stakeholder organization, two parents, and one provider association. DHS/MQD received public input from the second public forum as well as 3 written comments: two stakeholder organization and one provider association. The My Choice My Way advisory group reviewed all of the public comments. My Choice My Way advisory group revised the transition plan to include additional steps to assure continued public input throughout implementation of the transition plan. The timeframes for several functions were delayed by a month to allow increased public input. DHS/MQD has posted a question and answer on its website that responds to all of questions posed through public comment process.

INFORMATION ON THE MY CHOICE MY WAY TRANSITION PLAN
Individuals may continue to obtain information on Hawaii's My Choice My Way transition plan or submit questions or comments to:

Website: www.med-quest.us News and Events section

Email: mychoicemyway@medicaid.dhs.state.hi.us

Mailing address:
Department of Human Services, Med-QUEST Division
Attention: Health Care Services Branch
P.O. Box 700190
Kapolei, Hawaii 96709-0190

Telephone: 808-692-8094

Fax: 808-692-8087

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THE MY CHOICE MY WAY TRANSITION PLAN

The State of Hawaii has prepared this statewide transition plan in accordance with the new Home and Community Based Services (HCBS) regulations in 42 CFR Section 441.301(c)(4)(5) and Section 441.710(a)(1)(2). This plan addresses settings where home and community based services are provided through the Med-QUEST Division's QUEST Integration program and the 1915(c) waiver for persons with intellectual/developmental disabilities. Hawaii's plan outlines the activities to be undertaken by the State in partnership with the individuals who receive home and community based services, their families, friends, advocates, providers, and other stakeholders. The State of Hawaii will implement this plan in a manner that assures the health and safety of the individuals receiving HCBS. In addition, this transition plan does not replace previous assessments that an individual receiving HCBS may have had. The plan is organized into three sections: Assessment, Remediation, and Stakeholder Engagement/Public Input. Action steps, time frames and the products of the steps are included with each area of the HCBS Plan.

SECTION 1: ASSESSMENT

This area focuses on two key areas: 1) a system-level analysis of the State's regulations, standards, policies, licensing requirements, and other provider requirements that ensure settings to ensure full and on-going compliance with the federal requirements; and 2) an analysis of settings where HCBS are delivered to assess readiness to meet the federal regulations. The Assessment Phase employs a number of strategies to fully assess and determine compliance

ASSESSMENT ACTIVITIES- RESIDENTIAL SETTINGS

Action Item: Review State standards
Description: State will review current statutes, rules, regulations, standards, or other requirements to identify any needed changes for full compliance with the HCBS settings requirements.
Proposed Dates: 10/17/2014 to 4/1/2015
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HRS, HAR, Waiver Standards, contracts, HCBS rules, CMS guidance
Outcome: Identify areas where current language needs to be strengthened or revised for full compliance with the HCBS settings requirements. A systemic assessment is submitted as a component of the transition plan

Action Item: Compile list of all licensed/certified homes where HCB services are provided
Description: Build database with information on every home that provides HCB services: Provider name, address, numbers of participants, names of HCBS participants by setting
Proposed Dates: 01/01/15 to 01/30/15
Responsible Agencies: DOH/OHCA, DOH/DDD
Key Stakeholders: My Choice My Way advisory group are the decision makers on the factors to gather
Sources/documents: DOH/DDD-OCB, DOH/DDD-CMB, DOH/OHCA
Outcome: Obtain a comprehensive list of all licensed/certified homes

Action Item: Develop process for settings analysis and identify the assessors
Description: My Choice My Way workgroup advises State on development of the process for assessing and analyzing all HCBS settings. Workgroup develops a matrix for determining settings for on-site visits. State is responsible for identifying assessors of selected sites. The public will have input into the process for setting
Proposed Dates: 03/01/15 to 04/30/15
Responsible Agencies: DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Written process and training module for assessor. Share process and tools with providers.

Action Item: Develop the settings analysis tool
Description: The tool will assist in identifying current settings and classifying them into categories Category 1- Yes, meets requirements, Category 2- Not Yet, can meet with remediation, Category 3- No, cannot meet requirements and Category 4- Not yet, presumed not HCBS but State will require heightened scrutiny
Proposed Dates: 03/01/15 to 04/30/15
Responsible Agencies: DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance

Outcome: Share tool with providers. The setting analysis tool is submitted as a component of the transition plan.

Action Item: Revise transition plan to include assessment information as described below
Description: Transition plan will be updated to incorporate information found from assessment of providers and participants/consumers. Stakeholders will review transition plan for input.
Proposed Dates: 12/14/15 to 01/14/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Remediation phases of transition plan are updated to include additional information gathered from assessments.

Residential Participants/Consumers
Action Item: Develop the participant/ consumer experience survey
Description: HCBS participants and consumer advocacy entities will receive the survey. The survey will provide participant/consumer the opportunity to report their experience with their current HCBS settings.
Survey will: Formatted in larger font size (i.e., 18 point), include pictures, plain language, reading level, and referred to SAAC for input prior to issuing.
Proposed Dates: 01/01/15 to 02/01/15
Responsible Agencies: DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DD Council
Sources/documents: Crosswalk document of NCI and HCBS Rule. Other states' surveys and CMS exploratory questions
Outcome: A copy of the survey is submitted as a component of the transition plan

Action Item: Select a statistically significant sample of HCBS participants
Description: The state will select a statistically significant sample of HCBS participants who live in provider-owned or controlled settings to complete the survey.
Proposed Dates: 02/01/15 to 02/28/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN
Sources/documents: Compiled database stated above
Outcome: Identify a statistically significant sample of HCBS participants residing in provider- owned or - controlled settings. Method is submitted as a component of the transition plan.

Action Item: Conduct a participant/ consumer experience survey
Description: State will conduct an assessment using the Participant Experience Survey: Identify organization(s) that help participant/consumer complete survey (i.e., Case Management Agencies, DDD Case Managers, DD waiver agencies that do not provide residential services), utilize family members who have active contact with their relative to interpret the needs/experiences of non- verbal participants/consumers, ask SAAC to complete the survey, instructional memo prior to issuing, post form on-line to download in addition to mailing, add the survey to "survey monkey" for completion electronically, contact information for questions- e-mail and voice mail; and fax # to send back.
Proposed Dates: 04/01/15 to 05/31/05
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DD Council
Sources/documents: HCBS rules, CMS guidance
Outcome: Identify current level of compliance with the HCBS settings requirements. Survey response rate is a component of the transition plan

Action Item: Participant survey- Training for organizations
Description: Training provided to organizations to help the participant to complete survey.
Proposed Dates: 03/01/15 to 03/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Individuals assessing providers for compliance with HCBS settings will have training. The training presentation is submitted as a component of the transition plan

Action Item: Analysis of participant/consumer experience and provider surveys
Description: State will perform an analysis that confidentially matches providers with their participants/consumers to verify

if assessments are accurate. (Analysis data and match files are available upon request). Providers will be placed in a category of compliance.
Proposed Dates: 06/1/15 to 07/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DD Council
Sources/documents: HCBS rules, CMS guidance
Outcome: Providers are categorized after a complete analysis of the surveys. Method is submitted as a component of the transition plan. A provider summary of compliance is a component of the transition plan.

Residential Providers
Action Item: Develop the provider self- assessment survey
Description: The survey will assist in identifying provider readiness and classifying them into categories identified in Assessment #4. The public will have input into the provider survey.
Proposed Dates: 01/01/15 to 03/31/15
Responsible Agencies: DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: A copy of the survey is submitted as a component of the transition plan

Action Item: Identify providers who will complete self-assessment survey
Description: All providers will be given the opportunity to complete the Provider Self-Assessment Survey
Proposed Dates: 02/01/15 to 02/28/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Providers
Sources/documents: Compiled database stated above
Outcome: Identified providers to complete assessment. Method is submitted as a component of the transition plan.
Action Item: Conduct a provider self-assessment survey
Description: Providers will conduct a self- assessment of settings using the Provider Survey: Instructional memo prior to issuing, post form on-line to download in addition to mailing, add the survey to “survey monkey” for completion electronically, contact information for questions- e-mail and voice mail; and fax # to send back.
Proposed Dates: 04/01/15 to 05/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Identify current level of compliance with the HCBS settings requirements. Survey response rate is a component of the transition plan

Action Item: Analysis of participant/consumer experience and provider surveys
Description: State will perform an analysis that confidentially matches providers with their participants/consumers to verify if assessments are accurate. (Analysis data and match files are available upon request) Providers will be placed in a category of compliance.
Proposed Dates: 06/01/15 to 07/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DD Council
Sources/documents: HCBS rules, CMS guidance
Outcome: Providers are categorized after a complete analysis of the surveys. Method is submitted as a component of the transition plan. A provider summary of compliance is a component of the transition plan.

Action Item: Develop validation training for reviewers
Description: Training provided to reviewers to validate findings in the provider survey and aggregate data.
Proposed Dates: 08/01/15 to 09/30/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Individuals validating providers for compliance with HCBS settings will have training.

Action Item: Validation training for reviewers
Description: Training provided to reviewers to validate findings in the provider survey and aggregate data. Reviewers utilized "Big Tent" as communication platform during the validation period. The website served as a discussion board and

tracking tool which reviewers can view any validations that have been scheduled or already completed.
Proposed Dates: 10/08/15 to 10/08/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: The training presentation is submitted as a component of the transition plan

Action Item: Validate the provider self- survey
Description: State staff or designee will conduct site visits to a sample of providers to validate findings in the provider survey and aggregate data. State identifies areas for remediation. (Validation Data is available upon request)
Proposed Dates: 10/15/15 to 12/11/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: The validation tool is a component of the transition plan. Method is submitted as a component of the transition plan. A provider summary of compliance is a component of the transition plan.

Action Item: Conduct mandatory site visits for all category 4 settings
Description: State will perform a mandatory site visit to facilitate the heightened scrutiny process. Results of the visit will undergo public input prior to submission to CMS.
Proposed Dates: 01/2016 to 01/2016
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: State shall plan to provide explanation of how the setting meets HCBS settings requirements. A summary of all Category 4 settings with explanations is a component of the transition plan

ASSESSMENT ACTIVITIES- NON RESIDENTIAL SETTINGS
Action Item: Review State standards
Description: State will review current statutes, rules, regulations, standards, or other requirements to identify any needed changes for full compliance with the HCBS settings requirements.
Proposed Dates: 10/17/14 to 04/01/15
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HRS, HAR, Waiver Standards, contracts, HCBS rules, CMS guidance
Outcome: Identify areas where current language needs to be strengthened or revised for full compliance with the HCBS settings requirements. A systemic assessment is submitted as a component of the transition plan

Action Item: Compile list of all licensed/certified homes where HCB services are provided
Description: Build database with information on every home that provides HCB services: Provider name, address; numbers of participants; names of HCBS participants by setting
Proposed Dates: 01/01/15 to 01/30/15
Responsible Agencies: DOH/OHCA, DOH/DDD
Key Stakeholders: My Choice My Way advisory group are the decision makers on the factors to gather
Sources/documents: DOH/DDD-OCB, DOH/DDD-CMB, DOH/OHCA
Outcome: Obtain a comprehensive list of all licensed/certified homes

Action Item: Develop process for settings analysis and identify the assessors
Description: My Choice My Way workgroup advises State on development of the process for assessing and analyzing all HCBS settings. Workgroup develops a matrix for determining settings for on-site visits. State is responsible for identifying assessors of selected sites. The public will have input into the process for setting analysis.
Proposed Dates: 03/01/15 to 04/30/15
Responsible Agencies: DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Written process and training module for assessor. Share process and tools with providers.

Action Item: Develop the settings analysis tool
Description: The tool will assist in identifying current settings and classifying them into categories: Category 1- Yes, meets

requirements, Category 2- Not Yet, can meet with remediation, Category 3- No, cannot meet requirements, Category 4- Not yet, presumed not HCBS but State will require heightened scrutiny. The public will have input into the setting analysis tool.
Proposed Dates: 03/01/15 to 04/30/15
Responsible Agencies: DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Share tool with providers. The setting analysis tool is submitted as a component of the transition plan.

Action Item: Revise transition plan to include assessment information as described below
Description: Transition plan will be updated to incorporate information found from assessment of providers and participants/consumers. Stakeholders will review transition plan for input.
Proposed Dates: 12/14/15 to 01/14/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council
Sources/documents: HCBS rules, CMS guidance
Outcome: Remediation phases of transition plan are updated to include additional information gathered from assessments.

Non Residential Participants/Consumers
Action Item: Develop the participant/ consumer experience survey
Description: HCBS participants and consumer advocacy entities will receive the survey. The survey will provide participant/consumer the opportunity to report their experience with their current HCBS settings. Survey will: Formatted in larger font size (i.e., 18 point), include pictures, plain language, and reading level, and referred to SAAC for input prior to issuing.
Proposed Dates: 01/01/15 to 02/01/15
Responsible Agencies: DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DD Council
Sources/documents: Crosswalk document of NCI and HCBS Rule. Other states' surveys and CMS exploratory questions
Outcome: A copy of the survey is submitted as a component of the transition plan

Action Item: Select a statistically significant sample of HCBS participants
Description: The state will select a statistically significant sample of HCBS participants who live in provider-owned or -controlled settings to complete the survey.
Proposed Dates: 02/01/15 to 02/28/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN
Sources/documents: Compiled database stated above
Outcome: Identify a statistically significant sample of HCBS participants residing in provider- owned or - controlled settings. Method is submitted as a component of the transition plan.

Action Item: Conduct a participant/ consumer experience survey
Description: State will conduct an assessment using the Participant Experience Survey: Identify organization(s) that help participant/consumer complete survey (i.e., Case Management Agencies, DDD Case Managers, DD waiver agencies that do not provide residential services), utilize family members who have active contact with their relative to interpret the needs/experiences of non- verbal participants/consumers, ask SAAC to complete the survey, instructional information when issuing, post form on-line (and through survey monkey) to download in addition to mailing, contact information for questions- e-mail and voice mail, self-addressed envelope to return to DHS/MQD; and fax # to send back.
Proposed Dates: 04/01/15 to 05/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DD Council
Sources/documents: HCBS rules, CMS guidance
Outcome: Identify current level of compliance with the HCBS settings requirements. Survey response rate is a component of the transition plan

Action Item: Participant survey- Training for organizations
Description: Training provided to organizations to help the participant to complete survey.
Proposed Dates: 03/01/15 to 03/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance

Outcome: Individuals assessing providers for compliance with HCBS settings will have training. The training presentation is submitted as a component of the transition plan

Action Item: Analysis of participant/consumer experience and provider surveys
Description: State will perform an analysis that confidentially matches providers with their participants/consumers to verify if assessments are accurate. (Analysis data and match files are available upon request). Providers will be placed in a category of compliance.
Proposed Dates: 06/01/15 to 07/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DD Council
Sources/documents: HCBS rules, CMS guidance
Outcome: Providers are categorized after a complete analysis of the surveys. Method is submitted as a component of the transition plan. A provider summary of compliance is a component of the transition plan.

Non Residential Providers
Action Item: Develop the provider self- assessment survey
Description: The survey will assist in identifying provider readiness and classifying them into categories identified in Assessment #4. The public will have input into the provider survey.
Proposed Dates: 01/01/15 to 03/31/15
Responsible Agencies: DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: A copy of the survey is submitted as a component of the transition plan

Action Item: Identify providers who will complete self-assessment survey
Description: All providers will be given the opportunity to complete the Provider Self-Assessment Survey
Proposed Dates: 02/01/15 to 02/28/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Providers
Sources/documents: Compiled database stated above
Outcome: Identified providers to complete assessment. Method is submitted as a component of the transition plan.

Action Item: Conduct a provider self-assessment survey
Description: Providers will conduct a self- assessment of settings using the Provider Survey: Instructional memo prior to issuing, post form on-line to download in addition to mailing, add the survey to “survey monkey” for completion electronically, contact information for questions- e-mail and voice mail; and fax # to send back.
Proposed Dates: 04/01/15 to 05/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Identify current level of compliance with the HCBS settings requirements. Survey response rate is a component of the transition plan

Action Item: Analysis of participant/consumer experience and provider surveys
Description: State will perform an analysis that confidentially matches providers with their participants/consumers to verify if assessments are accurate. (Analysis data and match files are available upon request) Providers will be placed in a category of compliance.
Proposed Dates: 06/01/15 to 07/31/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DD Council
Sources/documents: HCBS rules, CMS guidance
Outcome: Providers are categorized after a complete analysis of the surveys. Method is submitted as a component of the transition plan. A provider summary of compliance is a component of the transition plan.

Action Item: Develop validation training for reviewers
Description: Training provided to reviewers to validate findings in the provider survey and aggregate data.
Proposed Dates: 08/01/15 to 09/30/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers

Sources/documents: HCBS rules, CMS guidance
Outcome: Individuals validating providers for compliance with HCBS settings will have training.

Action Item: Validation training for reviewers
Description: Training provided to reviewers to validate findings in the provider survey and aggregate data. Reviewers utilized "Big Tent" as communication platform during the validation period. The website served as a discussion board and tracking tool which reviewers can view any validations that have been scheduled or already completed.
Proposed Dates: 10/08/15 to 10/08/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: The training presentation is submitted as a component of the transition plan

Action Item: Validate the provider self- survey
Description: State staff or designee will conduct site visits to a sample of providers to validate findings in the provider survey and aggregate data. State identifies areas for remediation. (Validation Data is available upon request)
Proposed Dates: 10/15/15 to 12/11/15
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: The validation tool is a component of the transition plan. Method is submitted as a component of the transition plan. A provider summary of compliance is a component of the transition plan.

Action Item: Conduct mandatory site visits for all category 4 settings
Description: State will perform a mandatory site visit to facilitate the heightened scrutiny process. Results of the visit will undergo public input prior to submission to CMS.
Proposed Dates: 01/2016 to 01/2016
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: State shall plan to provide explanation of how the setting meets HCBS settings requirements. A summary of all Category 4 settings with explanations is a component of the transition plan

SECTION 2: REMEDIATION
The State must include remediation activities with timeframes for completion and the process for monitoring to assure that milestones are met as Hawaii moves toward full compliance with the HCBS Rule. Remediation will include revise administrative rules, provider standards, and training to assure compliance with revisions.

Action Item: Modify State standards
Description: State modifies statutes, rules, regulations, standards, or other requirements to identify any needed change for full compliance with the HCBS settings requirements.
Proposed Dates: 06/2015-10/2017
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: A systemic remediation is conducted. State standards are revised and are in full compliance with the HCBS rules requirements. A detailed remediation crosswalk is a component of the transition plan

Action Item: Issue site specific provider remediation letter for all category 4 settings
Description: State will issue a site specific provider remediation action letter for all category 4 settings. This process includes: Template letter for remediation, corrective action format, given 30 business days to respond with a corrective action plan; and required to attend mandatory trainings
Proposed Dates: 04/01/16 to 04/30/16
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Providers review the remediation requirements, develop a corrective action plan to meet the HCBS rules requirements, and attends all mandatory trainings.

Action Item: Issue provider remediation letter for all category 2 settings
Description: State will issue a remediation action letter for all category 2 settings. This process includes: Template letter for remediation and required to attend mandatory trainings
Proposed Dates: 06/01/2016 to 06/30/16
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Providers review the remediation requirements and attends all mandatory trainings.

Action Item: Develop operational procedures for compliance with revised State standards
Description: Identify areas within state standards that need changes to operational procedures for full compliance with the HCBS settings requirements. Through the systemic review and Category 1 settings- Use their operational practices as a guide for other providers for developing remediation Track and monitor proposed changes to the State standards while operational procedures are being developed
Proposed Dates: 01/2016 to 12/2016
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS Guidance
Outcome: Operational procedures are developed. Assure that operational protocols provide guidance to the caregivers related to the change in regulations.

Action Item: Mandatory provider training on revised operational procedures
Description: State will train providers on operational procedures to meet compliance with the HCBS settings requirements. Process includes a “train the trainer” model components for ongoing training, focused on person centered planning; and obtain a training certificate of completion
Proposed Dates: 01/2017 to 10/2017
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Providers understand operational procedures and obtains a training certificate of completion. Certificate will be presented during annual review until state standards are fully implemented.

Action Item: Provider oversight and monitoring- Category 4 settings
Description: State will provide oversight over all providers during the remediation period by: Verifying that the provider accepted the corrective action plan and provides the State with a remediation action plan, monitoring all providers by licensing/certification reviews annually and tracking remediation efforts by attending mandatory trainings
Proposed Dates: 04/01/16 to Ongoing
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Assure providers complete items stated in corrective action plan, maintain compliance with state standards, and attend all mandatory trainings.

Action Item: Provider oversight and monitoring- Category 1 and 2 settings
Description: State will provide oversight over all providers during the remediation period by: Monitoring all providers by licensing/certification reviews annually and tracking remediation efforts by attending mandatory trainings
Proposed Dates: 06/01/16 to Ongoing
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Assure providers maintain compliance with state standards and attend all mandatory trainings.

Action Item: Provider qualifications for new enrollees
Description: New prospective providers will receive information and technical assistance on HCBS settings requirements.
Proposed Dates: 11/07/15 to Ongoing
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance

Outcome: Provider is in full compliance with the HCBS rules requirements prior to providing services once state standards are enacted.

Action Item: Relocation plan- Participants in a setting that cannot meet the HCBS requirements
Description: State develops a relocation plan for participants in settings that cannot meet the HCBS requirements. The responsible state agency issues a notification letter to the provider and the participant, case manager/service coordinator will discuss different setting options in a person centered planning meeting, participant/consumer and case manager/service coordinator will work collaboratively during transition to setting of choice
Proposed Dates: 10/2018 to Ongoing
Responsible Agencies: DOH/OHCA, DHS/MQD, DOH/DDD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: Case manager/service coordinator and provider shall coordinate throughout transition process.

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SPECIFIC REMEDIATION STRATEGIES FOR THE HAWAII I/DD WAIVER

REVISIONS TO HAWAII ADMINISTRATIVE RULES:
Anticipated Date of Completion: 10/2017
Waiver participants reside in a number of different types of settings that have administrative rules or licensing requirements. DOH/DDD will coordinate revisions to the Hawaii Administrative Rules related to certified Adult Foster Homes for persons with DD. DOH/DDD will participate with the DOH Office of Health Care Assurance (OHCA) and DHS/MQD to licensing requirements.

REVISIONS TO THE MEDICAID WAIVER STANDARDS:
Anticipated Date of Completion: 9/2016
In order to ensure current and ongoing compliance with the HCBS requirements, Hawaii is reviewing and updating the Standards to reflect the HCBS requirements and other revisions related to this waiver renewal. The process includes stakeholders such as participants, families, providers, self-advocates and other community partners. DOH/DDD and DHS/MQD will revise the Standards to reflect the requirements for complying with the HCBS Final Rule.

REVISIONS TO DOH/DDD POLICIES AND PROCEDURES:
Anticipated Date of Completion: 12/2016
DOH/DDD, with approval of DHS/MQD, will develop policies and procedures that incorporate HCBS requirements.

REVISIONS TO NEW PROVIDER APPLICATIONS AND ORIENTATION:
Anticipated Date of Completion: 10/2016
DOH/DDD, with approval of DHS/MQD, has developed a checklist for any new provider applicant to evaluate its compliance with HCBS requirements at the time of enrollment. The checklist was based on the validation tool developed through the My Choice My Way Advisory Group. Additional revisions to the application are in process and will be used for any new applicant starting in July 2016. DOH/DDD will develop a new Orientation manual and offer training for prospective applicants to provide waiver services.

PROVIDER TRAINING:
Anticipated Date of Completion: 10/2017
DOH/DDD and DHS/MQD, in conjunction with the My Choice My Way Advisory Group, are designing mandatory training for providers whose settings are identified as Category 2 and 4. All-Provider meetings are held at least twice per year and general issues related to compliance with the HCBS Final Rule is a standing agenda item. Focused trainings will be provided related to provider-specific issues requiring remediation.

PROVIDER MONITORING FOR REMEDIATION AND ONGOING COMPLIANCE:
Anticipated Date of Completion: ongoing
The development of a provider corrective action plan is to ensure providers reach and maintain compliance with HCBS requirements. DOH/DDD will coordinator redesigning the monitoring tool and process for evaluating providers, including the addition of new strategies such as reviewing the benchmarks identified in the provider's remediation action plan, observations in the community and interviews with participants and families. Train state staff monitoring the providers to implement new strategies.

DEVELOP PROCESS FOR PROVIDER SANCTION AND DISENROLLMENTS

Anticipated Date of Completion: 6/2018
In the event the provider has gone through remediation activities and continues to demonstrate non-compliance with HCBS requirements, the state will develop a specific process for issuing provider sanctions up to disenrollment. This process is needed to ensure statewide compliance with HCBS requirements. The state will include stakeholders in discussions to develop the process. DOH/DDD and DHS/MQD will hold a formal public comment period to disseminate information on the provider sanctions and disenrollment criterion and to receive feedback from stakeholders.

SECTION 3: KEY STAKEHOLDER ENGAGEMENT AND PUBLIC COMMENT
Hawaii will use a transparent and robust stakeholder engagement process to provide information and gather input throughout the process of developing the transition plan and its implementation. Stakeholders were included on the My Choice My Way workgroup and are instrumental in developing the action steps, timeframes, and outcomes. DHS/MQD will announce the 30-day public comment period through website, newspaper, and public forum. DHS/MQD will retain all comments for future review.

Action Item: Announcement of public comment period
Description: Post the announcement in at least two forms. One will be public notice in newspapers, one will be public forum at Queen's conference center, recommend press release to Director's office, public announcements will occur, as needed, when there are significant changes to the transition plan
Proposed Dates: 12/16/14 to 1/30/15 and 12/30/15 to 03/01/16
Responsible Agencies: DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: Transition plan supporting documentation
Outcome: DHS/MQD obtains comments from stakeholders on its proposed transition plan

Action Item: Tribal council requirements
Description: Assure that tribal council requirements are met. Tribal consultation will occur, as needed, when there are significant changes to the transition plan
Proposed Dates: 12/12/14 to 01/15/15 and 12/30/15 to 03/01/16
Responsible Agencies: DHS/MQD
Key Stakeholders: Ke Ola Mamo
Sources/documents: Tribal consultation letter and draft transition plan
Outcome: DHS/MQD obtains comments from Ke Ola Mamo on its proposed transition

Action Item: Posting on website
Description: My Choice My Way will determine website where documents will be posted for review by public. Websites include: DHS/MQD, DOH/DDD, SPIN (website and Facebook page), and SAAC (Facebook page)
Proposed Dates: 11/14/14 to Ongoing
Responsible Agencies: DOH/DDD, DHS/MQD, DD council, SAAC, SPIN
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: Transition plan documents
Outcome: Documents posted and updated as needed. Web page hyperlinks make navigation easy

Action Item: Develop summary of transition plan
Description: Develop summary of transition plan document for communication to participants, consumers, families, and advocates. Formatted in larger font size (i.e., 18 point), include pictures; plain language; reading level and referred to SAAC for input prior to issuing.
Proposed Dates: 12/08/14 to 01/07/15 and 07/30/15 to 01/14/16
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: Summary of transition plan
Outcome: The summary of transition plan will be modified to a document that can be used in training and education.

Action Item: Public forum
Description: My Choice My Way shares the transition plan with stakeholders in a public forum (Statewide) to provide information and answer questions. Queen's conference center, include ASL interpreter, include amplifying devices, as needed and public forums will be held, as needed, when there are significant changes to the transition plan
Proposed Dates: 01/14/15 to 1/14/15 and 01/14/16 to 01/14/16
Responsible Agencies: My Choice My Way workgroup

Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: Transition plan documents
Outcome: DHS/MQD provides information to the public on the transition plan and is able to address questions from the community.

Action Item: Compile and retain public comments
Description: State will compile and summarize all comments and retain all public input per CMS requirements
Proposed Dates: 01/30/15 to Ongoing
Responsible Agencies: DHS/MQD
Key Stakeholders: DHS/MQD
Sources/documents: Transition plan documents
Outcome: Submit public comment summary as a component of the transition plan

Action Item: Revise transition plan as needed based on public comments
Description: Based on public comments, the state may revise the statewide transition plan to address comments.
Proposed Dates: 02/01/15 to 03/15/15 and 03/01/16 to 3/15/16
Responsible Agencies: My Choice My Way workgroup
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: Public comments summary
Outcome: Transition plan is revised as needed or additional evidence/rationale for state's decision if contrary to public comment.

Action Item: Develop communication channels for stakeholders
Description: Establish communication procedures, including by email and phone, for stakeholders to get questions answered with Frequently Asked Questions document compiled. Set up My Choice My Way e-mail account, determine one telephone number to call with questions, one primary way to receive comments, and compile Q&A for posting on websites identified above
Proposed Dates: 11/14/14 to Ongoing
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: Transition plan documents
Outcome: Mechanisms in place for responding to stakeholder questions, and compiling Frequently Asked Questions.

Action Item: Assure public input into all aspects of the process of implementing HCBS rules
Description: Establish mechanism to obtain input through the process of implementation of the HCBS rules. Develop e-mail list of individuals interested in implementation of the HCBS rules, provide updates to individuals as opportunities to provide public comment occur, and maintain updated information on the Med-QUEST Division website throughout implementation of the HCBS rules
Proposed Dates: 2/2/15 to Ongoing
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers, other stakeholders
Sources/documents:
Outcome: Mechanisms in place for obtaining public input throughout the process of implementing the HCBS rules. Detailed process for public input is a component of the transition plan

Action Item: Information sessions with participants, families, and advocates
Description: State and its partners will conduct informational sessions with waiver participants, families, and advocates that include in-person, webinar sessions, and written information, Understanding the final rule and how it may or may not effect waiver services, overview of Hawaii's proposed HCBS Transition Plan and how it will guide the path forward toward full compliance, and encourage participation during periods of public input.
Proposed Dates: Every 6 months to 01/2019
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Participants, families, SAAC, SPIN, DHS/MQD, DOH/OHCA, DOH/DDD, DD Council, Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: On an ongoing basis, those affected by the revised HCBS setting rules will have an opportunity to receive updated information. The presentation is a component of the transition plan

Action Item: Information sessions with providers
Description: State will conduct informational sessions, training and technical assistance opportunities for providers. Provider training and technical assistance include in- person, webinar sessions, and written information, understanding the final rule and how it may or may not effect waiver provider services, overview of Hawaii's proposed HCBS Transition Plan and how to achieve and maintain full compliance, and encourage participation during periods of public input. Organizations that have expressed interest include: Case Management Agencies, Community Care Foster, Family Home Association(s), Hawaii Waiver Providers Association (HWPA), Adult Residential Care Home Association(s)
Proposed Dates: Every 6 months to 01/2019
Responsible Agencies: DOH/DDD, DHS/MQD
Key Stakeholders: Providers
Sources/documents: HCBS rules, CMS guidance
Outcome: On an ongoing basis, providers will have an opportunity to receive updated information on HCBS rules. The presentation is a component of the transition plan

Acronyms
CMS- Centers for Medicare & Medicaid
CMB- Case Management Branch, DDD
CTA- Community Ties of America, Inc.
DOH- Department of Health
DDC- Hawaii State Council on Developmental Disabilities
DDD- Developmental Disabilities Division
DHS- Department of Human Services
HAR- Hawaii Administrative Rule
HCBS- Home and Community Based Services
HRS- Hawaii Revised Statutes
HWPA- Hawaii Waiver Provider Association
MQD- Med-QUEST Division
OHCA- Office of Health Care Assurance
SAAC- Self-Advocacy Advisory Council
SPIN- Special Parent Information Network

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

WAIVER AMENDMENT 02 (submitted February 2018):
In response to the public comments, DOH-DDD made three (3) changes to the proposed amendment:

-In Appendix J, the rate for Training & Consultation – Behavior Analysis was benchmarked against the rates for services provided by these professionals in other publicly funded programs. These benchmark amounts were adjusted to account for fewer billable hours when providing community-based waiver services compared to clinic-based services.

-In Appendix J, the rate for Registered Behavior Technician (RBT) delivering Personal Assistance/Habilitation (PAB), Adult Day Health (ADH) and Community Learning Services (CLS) was benchmarked against the rates for services provided by these RBT staff in other publicly funded programs. These benchmark amounts were adjusted to account for fewer billable hours when providing community-based waiver services compared to clinic-based services.

-In Appendix E, language was added to clarify that a legal guardian can assist an adult participant to choose a non-legal representative to be the employer in a consumer directed arrangement. Limits were added that the consumer directed employer must be at least 18 years of age or older. The legal guardian assisting the participant to choose a non-legal representative and the non-legal representative serving as the employer cannot be paid to provide waiver services to the participant.

Summary of Public Comments
The State received approximately 43 comments during the public notice and comment period. A summary of all comments was compiled and will be available on the DHS/MQD and DOH/DDD websites. Following is a summary of comments that resulted in changes to the waiver.

1. COMMENT:
Several stakeholders expressed concern about the ability to recruit and retain licensed behavior analysts to provide Training & Consultation in participants' homes and communities. Stakeholders indicated that the waiver rates are lower than what other payers reimburse these professionals, making it difficult for providers to compete for the small number of professionals available in Hawaii.
STATE RESPONSE:
The State appreciates the feedback and reviewed rates for services provided by these professionals in other publicly funded programs. The State also considered adjusting rates to account for fewer billable hours when providing community-based waiver services compared to clinic-based services.
IMPACT ON WAIVER:
The rate for Training & Consultation – Behavior Analysis was adjusted.

2. COMMENT:
Several stakeholders expressed concern about the ability to hire, train and retain Registered Behavior Technicians (RBT) to become compliant with Hawaii state law that requires RBTs under the direction of licensed behavior analysts to implement behavior support plans by January 1, 2019. Stakeholders reported challenges with training staff to become RBTs and then having staff leave for employment at other organizations paying higher rates than the waiver.
STATE RESPONSE:
The State appreciates the feedback and reviewed rates for services provided by these RBT staff in other publicly funded programs. The State also considered adjusting rates to account for fewer billable hours when providing community-based waiver services compared to clinic-based services.
IMPACT ON WAIVER:
The rate for RBTs delivering Personal Assistance/Habilitation (PAB), Adult Day Health (ADH), and Community Learning Services (CLS) was adjusted.

3. COMMENT:
One stakeholder indicated that language in the waiver appears to require the legal guardian to be the employer on behalf of the participant if the participant is unable to freely choose a non-legal designated representative without assistance. The stakeholder requested clarification that the legal guardian could assist the participant to select a non-legal designated representative.
STATE RESPONSE:
The State appreciates the stakeholder's input. The intent is to ensure the participant has the supports needed to use the consumer direction option by a designated representative that may or may not be the legal guardian and recognizes that some participants may need the assistance of their legal guardians to select a non-legal designated representative to serve as the consumer directed employer.
IMPACT ON WAIVER:
In Appendix E, language was changed to clarify that the legal guardian may assist the participant to select a non-legal designated representative to serve as the employer. A limitation was added that the consumer directed employer must be aged 18 or older. Language was added that the legal guardian assisting the participant to choose a non-legal representative and the non-legal representative serving as the employer cannot be paid to provide waiver services to the participant.

## Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   *(Do not complete item A-2)*

○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

*(Complete item A-2-a).*

◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:
**Department of Health, Developmental Disabilities Division**

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

## Appendix A: Waiver Administration and Operation

**2. Oversight of Performance.**

**a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

**b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
The Department of Human Services, Med-QUEST Division (DHS/MQD), as the Single State Medicaid Agency, administers all Medicaid waiver programs for Hawaii. In this capacity, DHS/MQD serves as the State's source for all matters pertinent to Medicaid. DHS/MQD provides technical consultation on issues relevant to Medicaid and Medicaid waiver to the Department of Health, Developmental Disabilities Division (DOH/DDD), which is the Waiver Operating Agency. DOH/DDD operates the waiver in accordance with the Memorandum of Agreement between DHS/MQD and DOH/DDD. The agreement is reviewed at least every five years aligned with the waiver renewal cycle and revisions are made if necessary.
DHS/MQD ensures the proper and efficient implementation of the waiver through the following:

1) Quality Assurance Reviews

These reviews are conducted by DOH/DDD and examine the quality of services provided via the waiver as implemented by DOH/DDD. It is a process that is quality focused and assesses the operating agency's role by conducting participant reviews. Information to be reviewed is gathered from participant and service provider records and interviews with participants, families and direct service workers. Indicators include but are not limited to: frequency and quality of worker/participant contacts; identification of measurable participant goals in service plans; documentation of services provided to achieve goals; responsiveness of the service planning process to participants' changing needs; adverse events regarding participants' health and safety; and quality of supervision and training provided to direct service workers by provider agencies to

achieve participant goals.

Remediation and improvement activities may be participant and/or system focused. Anticipated outcomes include improvements to case management and participant service planning, recruitment and training of providers and increasing the ability of DOH/DDD to effect needed improvements and changes. Concerns specific to individual participants reviewed are referred to the DOH/DDD case manager for remediation and follow up, with quarterly performance measure reports provided to the DHS/MQD. Depending on the severity and intensity of situations reviewed, the issue may be elevated to a cross department executive level discussion and remediation. Corrective actions vary according to the scope and severity of the identified problem.

2) DHS/MQD Management Compliance Reviews

DHS/MQD analyzes DOH/DDD reports that review the entire process of waiver involvement from initial eligibility determination to payments rendered for services and claims filed. The DOH/DDD reports include the following but are not limited to: the adequacy and efficiency of processes used to admit participants, how needs are assessed, how services are provided and how DOH/DDD monitors and tracks expenditures. These are compliance focused activities. After analyzing the reports submitted by DOH/DDD, DHS/MQD monitors remedial activities and outcomes and makes recommendations for system improvement to DOH/DDD as needed.

3) Regular Management Meetings between DHS/MQD & DOH/DDD

These “Collaboratives” are used to facilitate more effective communication between the oversight and operating agencies. Discussion topics include areas of concern identified by either DHS/MQD or DOH/DDD during their quality assurance processes, strategies to improve services or mitigate problems, and strategies to improve existing services and processes. Issues are addressed as identified, leading to new processes or procedures, and follow-up discussions to monitor that implementation occurred.

4) Transition Plan Meetings between DHS/MQD, DOH/DDD, & My Choice My Way Advisory Group

This is used to facilitate more effective communication between the Medicaid agency, operating agency, and the My Choice My Way advisory group on a monthly or more frequent basis as needed. Discussion topics include the implementation of the new Home and Community Based settings requirements, transition plan remediation activities, and ongoing provider monitoring. Issues are addressed as identified, leading to new processes or procedures, and follow-up discussions to monitor that the implementation occurred.

The frequency of quality assurance reviews conducted by DOH/DDD and reports received by DHS/MQD varies depending on the specific type of information gathered. Refer to Quality Improvement sections located in each appendix for specific information and frequencies.

## Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

There are three contracts that perform operational or administrative functions for the waiver on behalf of the Medicaid agency.

1) DHS/MQD contracts its Fiscal Intermediary (Fl) functions for the Medicaid Agency's fee-for service (FFS) program. The waiver program providers bill the contractor for payment.

2) DHS/MQD contracts to process payroll for consumer-directed providers.

3) DOH/DDD contracts to perform Financial Management Services to support participants using consumer-directed arrangements.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

## Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
Department of Human Services – Med-QUEST Division (DHS/MQD) for the Medicaid Fiscal Intermediary contract and the payroll processing contract

Department of Health – Developmental Disabilities Division (DOH/DDD) for the Financial Management Services contract

## Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The Medicaid Fiscal Intermediary contractor submits reports to DHS/MQD on a weekly basis. DHS/MQD monitors the contractor's performance through review of these weekly reports.

The Medicaid payroll processing contractor submits reports to DHS/MQD on a monthly basis that are reviewed to assure contract compliance.

The consumer-directed Financial Management Services contractor submits reports to DOH/DDD on a quarterly basis that are reviewed to assure contract compliance. DOH/DDD will submit quarterly reports to DHS/MQD that include an assessment of the contractor's performance on required activities per the scope of services.

## Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
*Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

| Function | Medicaid Agency | Other State Operating Agency | Contracted Entity |
|---|---|---|---|
| **Participant waiver enrollment** | ☑ | ☑ | ☐ |
| **Waiver enrollment managed against approved limits** | ☑ | ☑ | ☐ |
| **Waiver expenditures managed against approved levels** | ☑ | ☑ | ☐ |
| **Level of care evaluation** | ☑ | ☑ | ☐ |
| **Review of Participant service plans** | ☑ | ☑ | ☐ |
| **Prior authorization of waiver services** | ☑ | ☑ | ☐ |
| **Utilization management** | ☑ | ☑ | ☐ |
| **Qualified provider enrollment** | ☑ | ☑ | ☐ |
| **Execution of Medicaid provider agreements** | ☑ | ☐ | ☐ |
| **Establishment of a statewide rate methodology** | ☑ | ☑ | ☐ |
| **Rules, policies, procedures and information development governing the waiver program** | ☑ | ☑ | ☐ |
| **Quality assurance and quality improvement activities** | ☑ | ☑ | ☑ |

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

a. **Methods for Discovery: Administrative Authority**
***The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.***

i. **Performance Measures**

***For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application.*** *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver

- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

***Where possible, include numerator/denominator.***

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% of waiver policies/procedures developed or revised during the waiver year by DOH/DDD and approved by DHS/MQD. N: # of waiver policies/procedures developed or revised that are submitted during the waiver year by DOH/DDD and approved by DHS/MQD D: Total # of waiver policies/procedures developed or revised that are submitted during the waiver year**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DOH/DDD policies/procedures and Waiver standards**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#/% of new waiver applicants determined to be eligible for waiver services within 90 calendar days of receipt of a completed application. N: # of new waiver applicants determined to be eligible for waiver services within 90 calendar days of receipt of a completed application D: Total # of new waiver applicants determined to be eligible for waiver services in the quarter**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DOH/DDD Applications tracking log**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other** | |

| | | |
|---|---|---|
| | Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#/% of utilization reviews conducted by DOH/DDD in accordance with waiver approved policies/procedures. N: # of utilization reviews conducted by DOH/DDD in accordance with waiver approved policies/procedures D: Total # of utilization reviews conducted by DOH/DDD**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DOH/DDD Utilization Review tracking log**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**#/% of waiver reports submitted by DOH/DDD and received by DHS/MQD in accordance with schedule N: # of waiver reports submitted by DOH/DDD and received by DHS/MQD in accordance with schedule D: Total # of waiver reports required to be submitted by DOH/DDD to DHS/MQD**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Scheduled reports from DOH/DDD**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |

| | | |
|---|---|---|
| | | |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#/% of of scheduled validation activities completed by DHS/MQD N: # of scheduled validation activities completed by DHS/MQD D: Total # scheduled validation activities to be completed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Scheduled validation activities**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | |

| | | |
|---|---|---|
| | | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☑ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**#/% of new approved waiver providers in full compliance with the HCBS settings requirements prior to service delivery N: # of new approved waiver providers in full compliance with the HCBS settings requirements prior to service delivery D: Total # of new approved waiver providers**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Scheduled reports from DOH/DDD**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**#/% of waiver provider that are in full compliance with the HCBS settings requirements N: # of waiver provider settings that are in full compliance with the HCBS settings requirements D: Total # of waiver provider settings**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Scheduled reports from DOH/DDD**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| | |

**Performance Measure:**
**#/% of waiver providers in HPMMIS with a valid Medicaid provider agreement N: # of waiver providers in HPMMIS with a valid Medicaid provider agreement D: Total # of waiver providers in HPMMIS**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**MMIS Audit**

| Responsible Party for data collection/generation *(check each that applies):* | Frequency of data collection/generation *(check each that applies):* | Sampling Approach*(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☑ **Other**<br>Specify:<br>Conduent | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| Responsible Party for data aggregation and analysis *(check each that applies):* | Frequency of data aggregation and analysis*(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** | ☑ **Annually** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| Specify: | |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#/% of new CD employers enrolled by the FMS contactor in accordance with the FMS contract. N: # of new CD employers enrolled within 20 calendar days by the FMS. D: Total # of new CD employers referred to the FMS by the DOH/DDD.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Consumer-Directed FMS reports**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DHS/MQD is responsible for program monitoring and oversight. Identified problems are reviewed within appropriate quality committees to resolve issues timely and effectively. Corrective action plans and other remediation activities are logged and tracked and information is shared between DHS/MQD and DOH/DDD at regular scheduled meetings.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-1: Specification of the Waiver Target Group(s)

**a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| ☐ **Aged or Disabled, or Both - General** | | | | | |
| | ☐ | **Aged** | | | ☐ |
| | ☐ | **Disabled (Physical)** | | | |
| | ☐ | **Disabled (Other)** | | | |
| ☐ **Aged or Disabled, or Both - Specific Recognized Subgroups** | | | | | |
| | ☐ | **Brain Injury** | | | ☐ |
| | ☐ | **HIV/AIDS** | | | ☐ |
| | ☐ | **Medically Fragile** | | | ☐ |
| | ☐ | **Technology Dependent** | | | ☐ |
| ☑ **Intellectual Disability or Developmental Disability, or Both** | | | | | |
| | ☐ | **Autism** | | | ☐ |
| | ☑ | **Developmental Disability** | 0 | | ☑ |
| | ☑ | **Intellectual Disability** | 0 | | ☑ |
| ☐ **Mental Illness** | | | | | |
| | ☐ | **Mental Illness** | | | ☐ |
| | ☐ | **Serious Emotional Disturbance** | | | |

**b. Additional Criteria.** The State further specifies its target group(s) as follows:

HRS § 333F-1 defines intellectual disability as follows: "'Intellectual disability' means significantly sub-average general intellectual functioning resulting in or associated with concurrent with moderate, severe, or profound impairments in adaptive behavior and manifested during the developmental period."

HRS § 333F-1 defines developmental disabilities as follows: " 'Developmental disabilities' means a severe, chronic disability of a person which:
1) is attributable to a mental or physical impairment or combination of mental and physical impairments;
2) is manifested before the person attains age twenty-two;
3) is likely to continue indefinitely;
4) results in substantial functional limitations in three or more of the following areas of major life activity: self-care,

receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic sufficiency; and
5) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated."

Act 32, effective April 28, 2016 amended HRS 333F to define eligibility criteria for children ages 0 to 9:
"An individuals from birth to age nine who has a substantial developmental delay or specific congential or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described above, if the individual, without services and supports, has a high probability of meeting those criteria later in life."

**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (1 of 2)

**a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  **The limit specified by the State is** *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    *Specify:*

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services

furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

*Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

**The cost limit specified by the State is** *(select one)*:

- ○ **The following dollar amount:**

  Specify dollar amount:

  **The dollar amount** *(select one)*

  - ○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

    Specify the formula:

  - ○ **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- ○ **The following percentage that is less than 100% of the institutional average:**

  Specify percent:
- ○ **Other:**

  *Specify:*

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (2 of 2)

**Answers provided in Appendix B-2-a indicate that you do not need to complete this section.**

**b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

**c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

**Table: B-3-a**

| Waiver Year | Unduplicated Number of Participants |
|---|---|
| **Year 1** | 2735 |
| **Year 2** | 2767 |
| **Year 3** | 2799 |
| **Year 4** | 2831 |
| **Year 5** | 2863 |

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

◉ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

**Table: B-3-b**

| Waiver Year | Maximum Number of Participants Served At Any Point During the Year |
|---|---|
| **Year 1** | |
| **Year 2** | |
| **Year 3** | |
| **Year 4** | |
| **Year 5** | |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**c. Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (3 of 4)

**d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one*:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

**f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Individuals are admitted on a first-in, first-out basis. Exceptions to this order of admission as defined in the Hawaii Disability Rights Center Settlement Agreement (2005) will be made only for:

- an individual who requires crisis-level services in order to avoid institutionalization (persons who require crisis-level services are those for whom there are no supports available so that their health, safety and/or welfare are at risk); or

- an individual (or his/her legal guardian if applicable) who chooses to receive HCBS from a specific individual or provider and that individual or provider is not able to immediately provide services.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

**Answers provided in Appendix B-3-d indicate that you do not need to complete this section.**

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

**a.**

1. **State Classification.** The State is a *(select one)*:

- ○ **§1634 State**
- ○ **SSI Criteria State**
- ◉ **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ◉ **No**
   - ○ **Yes**

**b. Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

***Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)***

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☐ **SSI recipients**
- ☑ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☑ **Optional State supplement recipients**
- ☑ **Optional categorically needy aged and/or disabled individuals who have income at:**

  *Select one*:

  - ◉ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

    Specify percentage:

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☑ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  *Specify:*

  Blind or disabled individuals under section §1634(c) of the Act.

***Special home and community-based waiver group under 42 CFR §435.217)*** *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

  *Select one and complete Appendix B-5.*

  - ○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

*Check each that applies*:

☐ **A special income level equal to:**

*Select one*:

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

○ **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

☑ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
☑ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
☑ **Aged and disabled individuals who have income at:**

*Select one*:

◉ **100% of FPL**
○ **% of FPL, which is lower than 100%.**

Specify percentage amount: [ ]

☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

*Specify:*

Optional State Supplement participants.
Blind or disabled individuals under section §1634(c) of the Act.

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 7)

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.*

**a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

*Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**

*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).*

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
*(Complete Item B-5-c (209b State) and Item B-5-d)*

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
*(Complete Item B-5-c (209b State). Do not complete Item B-5-d)*

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
*(Complete Item B-5-c (209b State). Do not complete Item B-5-d)*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**b. Regular Post-Eligibility Treatment of Income: SSI State.**

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

**i. Allowance for the needs of the waiver participant** (*select one*):

◉ **The following standard included under the State plan**

(*select one*):

○ **The following standard under 42 CFR §435.121**

*Specify:*

○ **Optional State supplement standard**

○ **Medically needy income standard**

○ **The special income level for institutionalized persons**

(*select one*):

- ○ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of the FBR, which is less than 300%**

  Specify percentage:
- ○ **A dollar amount which is less than 300%.**

  Specify dollar amount:
- ◉ **A percentage of the Federal poverty level**

  Specify percentage: 100
- ○ **Other standard included under the State Plan**

  *Specify:*

- ○ **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ○ **The following formula is used to determine the needs allowance:**

  *Specify:*

- ○ **Other**

  *Specify:*

**ii. Allowance for the spouse only** (*select one*):

- ◉ **Not Applicable**
- ○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**
  *Specify:*

  **Specify the amount of the allowance** (*select one*):

  - ○ **The following standard under 42 CFR §435.121**

    *Specify:*

  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

*Specify:*

**iii. Allowance for the family** (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

*Specify:*

- **Other**

*Specify:*

**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**i. Allowance for the personal needs of the waiver participant**

(*select one*):

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ◉ **A percentage of the Federal poverty level**

  Specify percentage: 100

- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised

- ○ **The following formula is used to determine the needs allowance:**

  *Specify formula:*

- ○ **Other**

  *Specify:*

**ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  *Explanation of difference:*

**iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **The State does not establish reasonable limits.**
- ◉ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (5 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**e. Regular Post-Eligibility Treatment of Income: SSI State or §1634 State - 2014 through 2018.**

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (6 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

**Answers provided in Appendix B-5-a indicate the selections in B-5-c also apply to B-5-f.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (7 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.**

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

*As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

**a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

**i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. **Frequency of services.** The State requires (select one):

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

*If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

For individuals who do not require services on a monthly basis, face-to-face monitoring by the case manager will be at least quarterly with monthly telephone contacts with participant and/or others (e.g., caregivers, parents, guardians if applicable, providers, teachers, employers)

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ○ **By an entity under contract with the Medicaid agency.**

*Specify the entity:*

- ◉ **Other**

*Specify:*

DHS/MQD performs initial ICF-IID level of care (LOC) evaluations. DOH/DDD performs reevaluations.

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The initial LOC evaluation is performed by a DHS/MQD physician or physician designee.The DHS/MQD physician is licensed in the State of Hawaii. The physician designee is a consultant, also licensed in the State of Hawaii, contracted by DHS/MQD.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

a) As part of the initial evaluation, the following information is reviewed:
- DHS 1150C form documenting DOH/DDD recommendation and request for level of care authorization;
- physicians' recommendation completed and signed by the applicant's physician;
- results of any adaptive functional assessments;
- Psychological evaluation if performed;
- intake reports documenting personal/medical/family/social history, if no psychological evaluation is attached; and
- cognitive scores.

b) As part of the annual reevaluation, the following information is reviewed:
- annual physician recommendation completed and signed by the participant's physician;
- provider reports;
- in-person interviews by DOH/DDD case manager;
- services planning assessment(s), e.g., Inventory for Client and Agency Planning (ICAP), Supports Intensity Scale for Adults (SIS-A);
- adaptive functional assessment, e.g., Adaptive Behavioral Assessment System (ABAS);
- Individualized Service Plan (ISP); and
- updated psychological evaluation if performed for children, or for participants with mild-moderate intellectual disability, or for participants with major health changes whose cognitive and/or adaptive functioning may have changed.

The following criteria is used to determine when the adaptive functional assessment must be updated:
1. the ICAP score >80;
2. the current adaptive functional assessment is unclear;
3. cognitive and/or adaptive functioning has changed significantly; or
4. health has undergone major changes.

An updated psychological evaluation or updated testing is required when:
1. the adaptive functional assessment does not meet criteria (i.e., ABAS is in the mild range); and
2. for children at certain age groups with both IQ and adaptive scores in the mild to moderate range.

Based on analysis of the assessment results and additional information obtained, a determination is made whether the participant continues to meet eligibility for waiver services.

**e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

  Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

  The DHS 1150 (facility) form is different from the DHS 1150C (waiver) form in that the DHS 1150 evaluates an individual's need for active treatment 24 hours/day, 7 days a week.

  In both the initial evaluation and the annual re-evaluation, the types of core evaluations that are reviewed are the same (physician's recommendation or physician evaluation, psychological evaluations if performed, results of any adaptive functional assessments, cognitive scores, other reports that are available at the time of the initial or the re-evaluation). The outcomes are equivalent by virtue of the same methodologies used; the additional documents reviewed are only supplemental in nature and do not influence the outcome. As well, both processes require a review by the same Clinical Interdisciplinary Team (CIT) which reviews the same set of core documents if it is determined that the applicant/participant may not meet the level of care criteria or if the determination is questionable. If the CIT determines that the participant does not meet LOC, that recommendation is reviewed by the DHS/MQD Medical Director, who also reviews all initial LOC determinations. In FY2016 (quarters 1, 2 & 3 data), the CIT determined that two (2) participants did not meet LOC and both were validated by the DHS/MQD Medical Director.

**f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Details of the processes for Initial Evaluations and Annual Reevaluations are outlined below:

a) Initial evaluation:
DOH/DDD has responsibility for obtaining and reviewing the required documentation, that includes at a minimum:
1) application requesting services;
2) physician's recommendation; and
3) adaptive behavior assessments identifying functional levels.

A psychological evaluation of cognitive and adaptive functioning by a licensed psychologist will be required if the physician's evaluation indicates a diagnosis of intellectual disability (ID).

Additional information such as Department of Education assessment reports may be requested by DOH/DDD.

Based on the review, DOH/DDD determines whether the applicant meets criteria as defined by HRS Chapter 333F-1. If the applicant meets the criteria and is Medicaid eligible, DOH/DDD recommends to DHS/MQD that the applicant be evaluated as meeting the ICF-IID LOC. The recommendation is documented on the DHS 1150C form.

DHS/MQD receives the DHS 1150C form with attachments supporting the recommendation. The attachments

include the physician's evaluation completed and signed by the applicant's physician, results of an adaptive functional assessment, a psychological evaluation if performed, and intake reports documenting personal/medical/family/social history, if no psychological evaluation is attached. The cognitive and adaptive scores and classifications (ID or DD) are included in the DHS 1150C form.

DHS/MQD reviews the DHS 1150C form and attachments and determines the ICF-IID LOC. If the applicant meets LOC, the applicant is admitted into the waiver. If denied and not admitted into the waiver, DHS/MQD issues a Notice of Action to the applicant, stating the denial and the right to appeal.

DOH/DDD maintains in its files, all forms and reports received that provide information to evaluate the applicant, e.g. waiver application, evaluation(s) including psychological, physical therapy, occupational therapy, speech evaluation, and adaptive functioning assessments, Department of Education information; a client profile form that summarizes the applicant's intellectual functioning, levels of support needed in self-care, communication, mobility, individual living environment, employment or supported employment, self-direction, and cognitive retention (adaptive behavior), and physical health/etiological considerations. This information is available to DHS/MQD and CMS should it be requested.

b) Reevaluation:
Annually, the DOH/DDD reevaluates the participant's waiver eligibility using available information such as quarterly DOH/DDD case management reviews, provider reports, in-person interviews, the services planning assessment(s), e.g. Inventory for Client and Agency Planning (ICAP) or Supports Intensity Scale for Adults (SIS-A), the adaptive functional assessment, e.g. Adaptive Behavioral Assessment System (ABAS), and the Individualized Service Plan (ISP), as well as the annual physician's evaluation. A psychological evaluation will also be updated for children, for participants with mild-moderate intellectual disability, or for participants with major health changes whose cognitive or adaptive functioning may have changed. The DOH/DDD Qualified Intellectual Disability Professional (QIDP) – typically the Case Management Unit supervisor - determines whether the participant meets LOC. The LOC of participants whose cognitive or adaptive functioning may have changed (i.e. children, participants with mild ID and/or mild deficiencies in adaptive functioning, or participants with major health changes) are reviewed and determined by the DOH/DDD Clinical Interdisciplinary Team (CIT). The LOC reevaluation is maintained in the participant's file.

The DOH/DDD QIDP (typically the case management unit supervisor), following the case manager's recommendation determines whether the participant continues to meet LOC. If the participant's cognitive and adaptive functioning are unclear, a referral is made to the DOH/DDD clinical team for a determination. Any participant who does not meet LOC is reviewed by the clinical team as well as the DHS/MQD medical director prior to being discharged from the waiver. DOH/DDD provides the participant and/or guardian (if applicable) with a Notice of Action (NOA) stating the adverse action and the right to appeal to DOH/DDD and DHS/MQD.

**g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  *Specify the other schedule:*

**h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ○ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ◉ **The qualifications are different.**
  *Specify the qualifications:*

  The DOH/DDD Case Management Unit supervisors perform reevaluations. The case management supervisor is an individual who has at least one year of experience working directly with persons with intellectual disability or other developmental disability and who has graduated from an accredited university or is licensed/certified in

a field related to developmental disabilities.

Participants whose cognitive or adaptive functioning may have changed (children, or participants with mild ID and/or mild deficiencies in adaptive functioning, or participants with major health changes) are evaluated by the DOH/DDD Clinical Interdisciplinary Team (CIT), which is led by a DOH/ DDD physician licensed in the State of Hawaii.

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

Case management units maintain a tickler system to notify the DOH/DDD case managers at least three months in advance to complete the level of care reevaluation prior to the expiration of the existing evaluation. Completed level of care reevaluation documentation is kept in each participant's chart. This is a component of case management.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Evaluations and reevaluations are maintained in the participant's chart. The participant's original chart containing the evaluation/re-evaluation records is maintained in the assigned/respective case management unit.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Level of Care Assurance/Sub-assurances**

***The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.***

**i. Sub-Assurances:**

**a.** ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% of LOC evaluations completed for DDD participants applying for the Waiver**
**N: # of LOC evaluations completed for individuals applying for the waiver D:**
**Total # of all individuals applying for the waiver**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Database - DHS 1150C**

| **Responsible Party for data** | | **Sampling Approach** *(check each that applies):* |
|---|---|---|

| **collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☑ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**b.** ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**c.** ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% of initial LOC evaluations confirmed by the qualified DHS/MQD staff member N: # of initial LOC evaluations confirmed by the qualified DHS/MQD staff member D: Total # of initial LOC evaluations reviewed by the qualified DHS/MQD staff member**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Initial record review**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** |

| | | |
|---|---|---|
| | | Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DOH/DDD is responsible for tracking, peer, and supervisory review activities to assist in identifying trends and individual problems, e.g., untimely or inappropriate determinations. When individual issues are identified, DOH/DDD is responsible for addressing and remediating the issues. DOH/DDD submits the review results to DHS/MQD. DHS/MQD performs its own review of records reviewed by DOH/DDD that were determined to be out of compliance.

**ii. Remediation Data Aggregation**
**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☑ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

***Freedom of Choice.*** *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

*i. informed of any feasible alternatives under the waiver; and*
*ii. given the choice of either institutional or home and community-based services.*

**a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Prior to admission into the waiver, the DOH/DDD case manager reviews the applicant’s service needs and options under the I/DD Waiver program. The applicant and legal guardian (if applicable) are informed of the choice to receive services through the waiver as an alternative to institutional placement. This is documented on the “Service Authorization Form”.

**b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Signed copies of the Service Authorization Form are maintained in the participant’s chart. The participant’s original chart containing the evaluation/re-evaluation records is maintained in the assigned/respective case management unit.

## Appendix B: Participant Access and Eligibility

### B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
DOH/DDD provides oral interpreters to individuals with limited English proficiency, sign language services and TTY/TDD services. These services are provided at no cost to the individual. There are a number of state case managers who are multi-lingual. DOH/DDD may use technology to communicate with those who do not use speech as their primary means of communication. DOH/DDD also produces information in alternate formats as requested. The DOH/DDD offers LEP services in accordance with Act 290, later codified in sections 371-31 to -37, Hawaii Revised Statutes, to ensure that LEP individuals have equal, meaningful access to state-funded services in Hawaii. This law applies to state agencies and covered entities that receive state-funding and provide services to the public. It requires state agencies and covered entities to establish a language access plan; and take reasonable steps to ensure they provide meaningful access to limited English Proficient persons. By statute (Chapter 321C) the DOH Office of Language addresses the language access needs of limited English proficient persons and ensures meaningful access to services, programs, and activities offered by the DOH.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

**a. Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

| Service Type | Service | | |
|---|---|---|---|
| Statutory Service | Adult Day Health (ADH) | | |
| Statutory Service | Discovery & Career Planning (DCP) | | |
| Statutory Service | Individual Employment Supports | | |
| Statutory Service | Personal Assistance/Habilitation (PAB) | | |
| Statutory Service | Residential Habilitation (ResHab) | | |
| Statutory Service | Respite | | |
| Extended State Plan Service | Skilled Nursing | | |
| Other Service | Additional Residential Supports | | |
| Other Service | Assistive Technology | | |
| Other Service | Chore | | |
| Other Service | Community Learning Services (CLS) | | |
| Other Service | Environmental Accessibility Adaptations | | |
| Other Service | Non-Medical Transportation | | |
| Other Service | Personal Emergency Response System (PERS) | | |
| Other Service | Private Duty Nursing (PDN) | | |
| Other Service | Specialized Medical Equipment and Supplies | | |
| Other Service | Training and Consultation | | |
| Other Service | Vehicular Modifications | | |
| Other Service | Waiver Emergency Services | | |

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**

Statutory Service

**Service:**

Adult Day Health

**Alternate Service Title (if any):**

Adult Day Health (ADH)

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 04 Day Services | 04050 adult day health |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Services generally furnished as specified in the Individualized Service Plan (ISP), in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. The desired outcomes include measurable improvements in individual independence, increased participation in the community and other skill building that leads to increased community integration. Progress towards the participant's independence, community integration and skill development goals will be assessed and reviewed regularly to evaluate the measurable gains being made toward the goals. The participant's ISP may include a mix of Adult Day Health, Discovery & Career Planning, and Individual Employment Supports.

Individuals participate in structured age-relevant activities in a variety of settings other than their private residence.

Activities include training in activities of daily living (ADLs); instrumental activities of daily living (IADLs); communication; social skills and interpersonal relationships; choice making; problem-solving; teaching responsibility and team building, exploring interests through internet, books or other media available at the ADH location; and other areas of training identified in the ISP.

Transportation between the individual's place of residence and the ADH setting will be provided as a component part of ADH services, as is transportation to community settings during ADH attendance. The cost of this transportation is included in the rate paid to providers of ADH services. Transportation time between the participant's place of residence and the ADH location is not included in the ADH services time.

Any newly approved ADH providers during this waiver renewal period must be in full compliance with the CMS HCBS Settings Final Rule and be able to demonstrate the provision of services in fully integrated community settings. For settings that were operating prior to March 2014, the setting must be in compliance or working toward compliance as part of the My Choice My Way state transition plan.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

ADH does not duplicate services provided as Discovery and Career Planning, Community Learning Services or Individual Employment Supports.

ADH excludes:

1) any time spent by the participant working for pay, including contracts, enclaves, groups or individual

employment, regardless of the wage paid; and
2) supporting participants who independently perform activities that benefit the provider or its staff, i.e., independently doing services that would otherwise require the provider or its staff to pay for that service, such as landscaping, yard work, painting and housecleaning. This does not include routine chores and activities that participants engage in to maintain their common areas, practice responsibility and teamwork.

Personal care/assistance may be a component part of ADH services as necessary to meet the needs of a participant but may not comprise the entirety of the service.

ADH in combination with Community Learning Services-Group comprise a set of services to support participants to have a flexible mix of on-site and community-based services. The annual limit for this set of ADH and CLS-Group services is 1560 hours. The distribution of ADH and CLS-Group services within the 1560 hours will be determined through the person-centered planning process and specified in the ISP. Requests for services in excess of 1560 hours annually are reviewed through an exception process on a case-by-case basis.

ADH services may not be provided at the same time (same 15-minute period) as another face-to-face service, such as PAB, Community Learning Services, Discovery & Career Planning, Respite or Individual Employment Supports. Individual Employment Supports (face-to-face) excludes certain activities where the participant may or may not be present, such as job development, discussions with the employer or other supported employment-related activities where the participant is not present. When these Individual Employment Supports are delivered at the same time the participant is at ADH, both services may be reported.

Services will not duplicate services available to a participant under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)), but may complement those services beyond any program limitations.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Adult Day Health (ADH)**

**Provider Category:**
Agency
**Provider Type:**
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDD

**Frequency of Verification:**
1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Statutory Service

**Service:**
Prevocational Services

**Alternate Service Title (if any):**
Discovery & Career Planning (DCP)

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| **Category 2:** | **Sub-Category 2:** |
| **Category 3:** | **Sub-Category 3:** |
| **Category 4:** | **Sub-Category 4:** |

**Service Definition** *(Scope):*
Discovery & Career Planning (DCP) combines elements of traditional prevocational services with career planning in order to provide supports that are ongoing throughout the participant's work career. Discovery and Career Planning is based on the belief that all individuals with intellectual and developmental disabilities can work when given the opportunity, training, and supports that build on an individual's strengths, abilities and interests. This service is designed to assist participants to: 1) acquire skills to achieve underlying habilitative goals that are associated with building skills necessary to perform work in integrated community employment; 2) explore possibilities/impact of work; and 3) develop career goals through career exploration and learning about personal interests, skills and abilities.. The outcome of DCP services is to complete or revise a career plan and develop the knowledge and skills needed to get a job in a competitive, integrated employment or be self-employed. Services are time-limited and shall increase individual independence and reduce level of service need. The participant's Individualized Service Plan (ISP) will include employment-related goals and the DCP activities are designed to support the employment goals.

Participation in DCP is not a pre-requisite for receiving Individual Employment Supports. The participant's ISP may include a mix of Adult Day Health Community Learning, DCP, and Individual Employment Supports. When used as a wrap-around support for participants who work part-time, DCP must be coordinated with any Individual Employment Services or any other non-residential supports the participant is receiving to reinforce participation in competitive integrated employment as a priority life activity.

Personal care/assistance may be a component of DCP services, but does not comprise the entirety of the service.

Discovery and Career Planning services are time-limited activities that include the following:
1) exploring employment goals and interest to identify a career direction;
2) community-based formal or informal situational assessments;
3) task analysis activities;
4) mobility training to be able to use fixed route and/or paratransit public transportation as independently as possible;
5) skills training/ mentoring, work trials, apprenticeships, internships, and volunteer experiences;
6) training in communication with supervisors, co-workers and customers; generally accepted workplace conduct and attire; ability to follow directions; ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and other skills as identified through the person-centered planning process;
7) broad career exploration and self-discovery resulting in targeted employment opportunities including activities such as job shadowing, information interviews and other integrated worksite based opportunities;
8) interviewing, video resumes and other job-seeking activities;
9) transitioning the participant into employment supports for individualized competitive integrated employment or self-employment from: a) volunteer work, apprenticeships, internships or work trials ; b) from a job that pays less than minimum wage; and c) from a more segregated setting or group employment situation;
10) financial literacy, money management, and budgeting; and
11) when assisting a participant who is already employed, activities to support the participant in explore other careers or opportunities.

Participants receiving DCP may be compensated in accordance with applicable Federal laws and regulations and the provision of DCP is always delivered with the intention of leading to permanent integrated employment at or above the minimum wage in the community.

Transportation to and from activities will be provided or arranged by the provider and included in the rate paid for the service. The provider shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the participant with priority given to the use of public transportation when appropriate.

Any newly approved Discovery & Career Planning providers during the waiver renewal period must be in full compliance with the CMS HCBS Settings Final Rule and be able to demonstrate the provision of services in fully integrated community settings. For settings that were operating prior to March 2014 as Prevocational Service providers, the setting must be in compliance or working toward compliance as part of the My Choice My Way state transition plan.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Discovery & Career Planning (DCP) services are limited to a maximum of 24 months of cumulative DCP with an expectation that the participant is working at the end of this period in a competitive integrated job or is self-

employed. An extension of the authorization may be made for a second 24-month interval if the participant lost his or her job or has experienced a major gap in employment due to health or other issues.

DCP are not intended to teach the participant task specific skills to perform a particular job. This is provided under other waiver services: Individual Employment Supports.

DCP services may not be provided at the same time (same 15-minute period) as another face-to-face service, such as PAB, Adult Day Health, Community Learning Services, Respite or Individual Employment Supports. Individual Employment Supports (face-to-face) excludes certain activities where the participant may or may not be present, such as job development, discussions with the employer or other supported employment-related activities where the participant is not present. When these non-face-to-face Individual Employment Supports activities occur at the same time (same 15-minutes) that the participant is receiving face-to-face DCP, both services can be billed. The provider shall document the nature of both activities to prevent duplication of services.

Services will not duplicate or replace services available to a participant under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)), but may complement those services beyond any program limitations.

DCP excludes:
1) providing vocational services where participants are supervised for the primary purpose of producing goods or performing services, including services provided in sheltered workshops and contract work at less than minimum wage;
2) payments that are passed through to users of DCP, including payments of wages or stipends for internships or work experience;
3) paying employers incentives to encourage or subsidize the employer's participation in internships or apprenticeships;
4) supporting participants to volunteer at for-profit organizations or businesses or to independently perform services without pay ("volunteering") that benefit the waiver service provider or its staff and which would otherwise require the provider or staff to pay to have that service completed, such as landscaping, painting, or housecleaning;
5) supporting any activities that involve payment of sub-minimum wage; and
6) offering services in settings that do not meet the criteria included in the service definition.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Discovery & Career Planning (DCP)**

**Provider Category:**

Agency

**Provider Type:**

DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DOH/DDD

**Frequency of Verification:**

1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Supported Employment

**Alternate Service Title (if any):**

Individual Employment Supports

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| | |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope):*
Individual Employment Supports are based on the belief that all individuals with intellectual and developmental disabilities can work and that individuals of working age should be provided the supports necessary not only to gain access to and maintain employment in the community, but to advance in their chosen fields and explore new employment options as their skills, interests, and needs change. Individual Employment Supports are designed to maximize the participant's skills, talents, abilities and interests. The goal of Individual Employment Supports is employment in a competitive integrated work setting. This is defined as a work place in the community or self-employed, where the participant receives at least minimum wage or the prevailing rate for that work, where the majority of individuals do not have disabilities, and which provides opportunities to interact with non-disabled individuals to the same extent that individuals employed in comparable positions would interact. Services may be ongoing based on the support needs of the participant and shall increase individual independence and reduce level of service need.

Individual Employment Supports are provided in accordance with the participant's Individualized Service Plan (ISP) and developed through a detailed person-centered planning process, which includes annual assessment of employment goals. The participant's ISP may include a combination of Adult Day Health, Community Learning Services, Discovery & Career Planning, and Individual Employment Supports.

Individual Employment Supports are activities needed to obtain and maintain an individual job in competitive or customized employment or self-employment, including home-based self-employment and may include:
1) on-going job coaching services to include on-the-job work skills training and systematic instruction required to perform the job with fading of supports as the participant becomes more confident and competent in the job to the extent possible;
2) person-centered employment planning;
3) job development, carving, or customization;
4) negotiations with prospective employers;
5) assistance for self-employment, including a) assist in identifying potential business opportunities; b) assist in the development of a business plan, including potential sources of business financing and other assistance needed to develop and launch a business; c) identification of supports needed in order for the participant to operate the business; and d) ongoing assistance, counseling and guidance once the business has been launched;
6) worksite visits as needed by the individual or employer to assess for new needs and to proactively support the participant to address issues that arise (typically at the worksite unless the individual requests visits outside the worksite or worksite visits are deemed too disruptive by the employer);
7) ongoing evaluation of the individual's job performance except for supervisory activities rendered as a normal part of the business setting; training related to acclimating to or acceptance in the workplace environment, such as effective communication with co-workers and supervisors and when and where to take breaks and lunch;
8) individualized problem-solving/advising with the participant about issues that could affect maintaining employment;
9) training in skills to communicate disability-related work support and accommodation needs;
10) assessing the need for basic job aids, facilitating referral through the participant's DOH/DDD case manager for assistive technology assessment and acquisition of assistive technology from Division of Vocational Rehabilitation;
11) facilitating referral through the DOH/DDD case manager to a Discovery & Career Planning provider for financial literacy, money management and budgeting;
12) providing information and training, as appropriate, for employers related to disability awareness, use of tax credits and other incentives, individual disability-specific training, and use of basic job aids and accommodations (may or may not be delivered with the participant present); and
13) training in arranging and using transportation, such as fixed route public transportation or paratransit services to get to and from the participant's place of employment;
14) career advancement services.

When Individual Employment Supports are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by the participant

receiving waiver services as a result of his or her disabilities.

Personal care/assistance may be a component of Individual Employment Supports, but does not comprise the entirety of the service. If ongoing assistance is needed beyond the supports provided by the job coach, the DOH/DDD case manager may authorize Community Learning Services in the workplace. CLS is a distinct service that does not duplicate the job coach services. When the job coach is on-site providing a face-to-face service to the participant, the CLS worker shall not bill for the same time (same 15-minute period). If different agencies provide the two services, the CLS and IES providers will coordinate visits to ensure that the CLS provider does not bill at the same time (same 15 minute period) that a face-to-face job coaching activity is delivered by the IES provider. Service delivery is monitored by the case manager through quarterly reports, as well as by the DOH/DDD monitoring team. All service delivery is subject to fiscal audit by DOH/DDD.

Transportation to and from the supported employment activities shall be arranged by the provider and participant and is included in the rate for this service.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) but may complement those programs beyond any program limitations.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Services are limited to a maximum of eight (8) hours per day, 40 hours per week.

Individual Employment Supports exclude:
1) supporting the participant to perform work that benefits the waiver provider, regardless of wage paid, including paid employment in an enterprise owned by the provider of Individual Employment Supports or a relative of that provider;
2) paying incentives, subsidies or for unrelated vocational training expenses such as the following:
- incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment arrangement;
- payments that are passed through to participants receiving Individual Employment Supports;
- payments for training that is not directly related to the participant's Individual Employment Supports;
3) paying expenses with starting up or operating a business;
4) continuing the service for the sole purpose of providing transportation to and from the place of employment once the participant no longer needs job coaching; and
5) paying for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business.

Individual Employment Supports are typically delivered face-to-face with the participant. Exceptions where the participant may or may not be present include job development, negotiations with prospective employers or meetings and phone calls where the participant may not be present, such as discussions with the supervisor or family). Individual Employment Supports that are face-to-face may not be provided at the same time (same 15-minute period) as another face-to-face service, such as PAB, Community Learning Services, Discovery & Career Planning, or Respite.

Services will not duplicate or replace services available to a participant under a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)), but may complement those services beyond any program limitations.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Individual Employment Supports**

**Provider Category:**

Agency

**Provider Type:**

DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DOH/DDD

**Frequency of Verification:**

1st of month of service for initial evaluation and every succeeding 12th month thereafter.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Habilitation

**Alternate Service Title (if any):**

Personal Assistance/Habilitation (PAB)

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| | |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*
Personal Assistance/Habilitation (PAB) is a range of assistance or habilitative training provided primarily in the participant's home to enable a participant to acquire, retain and/or improve skills related to living in his or her home. PAB services are identified through the person-centered planning process and included in the Individualized Service Plan (ISP) to address measurable outcomes related to the participant's skills in the following areas:
1) Activities of Daily Living (ADL) skills: eating, bathing, dressing, grooming, toileting, personal hygiene and transferring;
2) Instrumental Activities of Daily Living (IADL): light housework, laundry, meal preparation, arranging public transportation, preparing a grocery or shopping list, using the telephone, learning to self-administer medication and budgeting:
3) mobility;
4) communication; and
5) social skills and adaptive behaviors.

PAB may be provided through hands-on assistance (actually performing a task for the participant), training (teaching the participant to perform all or part of a task), or multi-step instructional cueing (prompting the participant to perform a task). Such assistance also may include active supervision (readiness to intervene as necessary when there is greater than a 50% likelihood that assistance will be required during the supervision episode).

Through the person-centered planning process, the participant is afforded the choice and flexibility to decide the skills/activities to work on in the home setting using PAB and the skills/activities to work on in community-based settings using other waiver services. A different service. Community Learning Service, is delivered outside the participant's home and focuses on community-based skill development opportunities.

Transportation is not included in PAB services.

Personal assistance/habilitation (PAB) services may be provided on an episodic or on a continuing basis.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
PAB services are provided in the participant's own home or family home. PAB services are not provided in any licensed or certified residential home.

Out-of-State PAB services cannot exceed 14 calendar days in a fiscal year (July 1 through June 30) for one staff to accompany the participant. An exception process is in place for situations that could arise during travel that would require additional authorization of hours. Out-of-state PAB is approved for the same amount of hours as the current authorization.

For participants under age 21, PAB may not be delivered if such services have been determined to be medically

necessary EPSDT services to be provided through the QUEST Integration (QI) health plans.

PAB services may not be delivered during the school day or educational hours as defined for that student through the Individualized Education Plan (IEP), such as a reduced attendance schedule, home-school, or hospital services. If a parent chooses to remove a minor-aged student from school, the waiver will not provide PAB services during the times when the participant would otherwise be attending school.

PAB shall not be provided at the same time (same 15-minute period) as Respite services.

An individual serving as a designated representative for a waiver participant using the consumer-directed option may not provide PAB.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

**Service Delivery Method** *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Consumer Directed Direct Support Worker (DSW) |
| Agency | DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Personal Assistance/Habilitation (PAB)**

**Provider Category:**
Individual
**Provider Type:**
Consumer Directed Direct Support Worker (DSW)
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Consumer directed – must be at least 18 years of age, complete criminal history check, be able to work in the United States, meet qualifications in job description - trained and supervised by the participant/designated representative
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Employer/Designated Representative
**Frequency of Verification:**

1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Personal Assistance/Habilitation (PAB)**

**Provider Category:**
Agency
**Provider Type:**
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDD
**Frequency of Verification:**
1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Statutory Service
**Service:**
Residential Habilitation
**Alternate Service Title (if any):**
Residential Habilitation (ResHab)

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope):*
Residential Habilitation (ResHab) are individually tailored supports that assist with the acquisition, retention or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living and instrumental activities of daily living, community inclusion, transportation, and social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential Habilitation does not include general care and protective oversight and supervision which are required under the home's license or certification requirements. Residential Habilitation is a service, not a setting.

Payment is not made for the cost of room and board, the cost of building maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a residence required to assure the health and welfare of residents, or to meet the requirements of the applicable life safety code. The method by which the costs of room and board are excluded from payment for Residential Habilitation is specified in Appendix J.

Residential Habilitation may be provided in licensed and/or certified homes or in the community but does not duplicate services furnished to the participant as other types of habilitation; participants can receive Residential Habilitation on the same day as non-residential services.

Transportation between the participant's residence and activities in the community is provided as a component of Residential Habilitation services and the cost of transportation is included in the rate paid.

Personal care/assistance may be a component part of Residential Habilitation services but may not comprise the entirety of the service.

Provider-owned or –leased settings must be compliant with the Americans with Disability (ADA) requirements. These settings must also provide a home-like environment. Any newly approved providers (settings that begin providing services on and after July 1, 2016) must be in full compliance with the CMS HCBS Settings Final Rule. For settings that were operating prior to March 2014, the setting must be in compliance or working toward compliance as part of the My Choice My Way state transition plan.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
The provisions of routine housekeeping, meal preparation and chore activities are integral to and inherent in the provision of residential habilitation services in licensed and certified settings. Chore Services shall not be approved for ResHab settings.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Residential Habilitation (ResHab)**

**Provider Category:**
Agency
**Provider Type:**
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDD
**Frequency of Verification:**
1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Statutory Service
**Service:**
Respite
**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope):*
Respite services are only provided to participants living in family homes and are furnished on a short-term basis to provide relief to those persons who normally provide uncompensated care for the participant for at least a portion of the day. Respite may be provided in the participant's own home, the private residence of a respite care worker, DD Domiciliary Home, DD Adult Foster Home, Adult Residential Care Home, or Expanded Adult Residential Care Home.

If the participant requires nursing assessment, judgment and interventions during Respite, the service may be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the supervision of a RN.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Multiple episodes of respite may occur during the year. However, any episode of respite is limited to 14 consecutive days. The total annual amount of Respite is limited to 760 hours. The DOH/DDD will perform further authorization on a case-by-case basis.

Respite services provided by a RN or LPN are available only to participants receiving Private Duty Nursing (PDN), through QUEST Integration EPSDT services (for children under age 21) or through the 1915(c) I/DD waiver service (for adults age 21 and older). Respite services provided by a RN or LPN must be obtained from a Medicaid Waiver provider. Respite services provided by a nurse must be provided using the 15-minute code only. Respite services provided by a nurse shall not be authorized to supplement PDN hours on a regular scheduled basis.

Respite services provided by a RN or LPN cannot be consumer-directed.

Federal financial participation is not claimed for the cost of room and board in any of these settings. Respite is not available in long-term care facilities.

Respite cannot be used during times when the person providing care is being paid to deliver another waiver service, such as PAB or CLS. It is limited to providing for relief during times when the person is not being paid to provide care to the participant.

Daily Respite is limited to those services provided in licensed or certified residential homes. Respite provided in the participant's own home or the private residence of a respite care worker must use the 15-minute Respite code.

Respite services provided on an hourly basis are not delivered during the same time (same 15-minute period) that the following face-to-face services are delivered: PAB, ADH, Discovery & Career Planning, Individual

Employment Supports, Private Duty Nursing (PDN) or Community Learning Services.

A guardian or legally responsible adult (parent of a minor aged 17 and younger or spouse of the participant) cannot be the Respite worker. An individual serving as a designated representative for a waiver participant using the consumer-directed option may not provide Respite.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

**Service Delivery Method** *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Consumer Directed Direct Support Worker (DSW) |
| Agency | DOH/DDD Waiver Provider, i.e., agency with Medicaid Provider agreement |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**
Individual
**Provider Type:**
Consumer Directed Direct Support Worker (DSW)
**Provider Qualifications**

**License** *(specify)*:

**Certificate** *(specify)*:

**Other Standard** *(specify)*:
Consumer directed – at least 18 years of age, complete criminal history check, be able to work in the United States, meet qualifications in job description - trained and supervised by the participant/designated representative

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Employer/Designated Representative
**Frequency of Verification:**
1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Respite**

**Provider Category:**
Agency

**Provider Type:**
DOH/DDD Waiver Provider, i.e., agency with Medicaid Provider agreement

**Provider Qualifications**

**License** *(specify):*
If Respite services are delivered by a nurse employed by the agency:

Licensed Registered Nurse per Chapter 457, Hawaii Revised Statutes

Licensed Practical Nurse per Chapter 457, Hawaii Revised Statutes

**Certificate** *(specify):*

**Other Standard** *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDD

**Frequency of Verification:**
1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Extended State Plan Service

**Service Title:**
Skilled Nursing

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope):*
Skilled nursing services include services listed in the ISP that are within the scope of the State's Nurse Practice Act and require the education, assessment, judgment and intervention of a registered professional nurse (RN), or licensed practical nurse (LPN) under the supervision of an RN. The RN and LPN are licensed to practice in the State of Hawaii. Skilled Nursing Services include the provision of nursing assessment, treatments and observation consistent with physician's orders and in accordance with the written health care plan in the participant's record. The nurse provides detailed notes of interventions, judgments and assessments and makes documentation available at the frequency specified in the ISP for the DOH/DDD case manager and upon request, review by DOH/DDD.

Skilled Nursing services are provided on an intermittent, part-time and time-limited basis. "Intermittent and part-time" is defined as occurring at irregular intervals, sporadic, and not continuous.

Personal care/assistance may be provided when incidental to the delivery of Skilled Nursing as necessary to meet the needs of a participant but may not comprise the entirety of the service.

The DOH/DDD actively review participants when skilled nursing hours reach certain thresholds that would indicate the service is not intermittent, time-limited and/or part-time. DOH/DDD will also assess whether these participants still meet criteria for and can benefit from the waiver or whether intense medical needs requiring more continuous nursing care make them more appropriate for QUEST Integration (QI) services from the health plans.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Skilled Nursing will be phased out effective June 30, 2019. Depending on the participant's needs and best approach to meet those needs, participants may transition to waiver services (i.e., Private Duty Nursing, Respite by a nurse) or health plan services (i.e., State plan or Long Term Supports and Services - LTSS).

Skilled Nursing Services under the waiver may not replace the services available under the State Plan. Medically necessary skilled nursing services that are covered under the State Plan are provided by the QUEST Integration (QI) health plans. For participants under age 21, Skilled Nursing Services may not be delivered if such services have been determined to be medically necessary EPSDT services to be provided through the QUEST Integration health plans.

Skilled Nursing Services shall not be used in place of PAB services where the participant's needs could be met with a trained direct support worker performing nurse-delegated tasks but the agency has not hired and trained a worker. An exception may be requested through the DOH/DDD in an emergency situation for short-term coverage while the agency hires and trains a PAB worker.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Skilled Nursing**

**Provider Category:**
Agency
**Provider Type:**
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
**Provider Qualifications**
**License** *(specify):*
Licensed Registered Nurse per Chapter 457, Hawaii Revised Statutes

Licensed Practical Nurse per Chapter 457, Hawaii Revised Statutes
**Certificate** *(specify):*

**Other Standard** *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State. Each agency must follow the Hawaii State Administrative Rules regarding the Hawaii Nurse Practice Act.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDD
**Frequency of Verification:**
1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Additional Residential Supports

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| | |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

This service provides a short-term hourly direct support worker to assist the Residential Habilitation (ResHab) caregiver when a participant experiences a physical or behavioral change that exceeds the required level of care the caregiver must provide in accordance with licensure or certification requirements. The outcome of this service is to stabilize a participant's placement in the ResHab home, support the family unit, prevent loss of placement and/or prevent a crisis. The service in intended to be short-term (defined as less than 60 days).

Additional Residential Supports may be used to provide an additional staff person on a time-limited basis where a participant's documented physical or behavioral change prevents the ResHab caregiver from implementing the goals identified in the Individualized Service Plan (ISP) for assistance with adaptive skill development, assistance with activities of daily living and instrumental activities of daily living, community inclusion, and social and leisure skill development. This additional staff support may be used for changes to the participant's physical abilities due to a significant change in health condition caused by illness, injury, surgery or where a change in the participant's behaviors requires an additional staff to implement the behavior strategies while the participant is assessed to identify any physical, environmental or mental health issues impacting the change in behavior.

The service must be specified in the Individualized Service Plan (ISP). Additional Residential Supports is a distinct and separate service that can be billed in 15-minute increments during the ResHab day. The service is only available when documented needs exceed the staffing level assumed and funded in the rate model for the participant's applicable ResHab rate. When requesting the service, the provider must submit a proposed staffing schedule that illustrate the baseline ResHab staffing and the Additional Residential Supports hours being requested. Providers will be required to maintain daily staffing logs, timesheets, and/ or other documentation that demonstrates total staffing hours including those hours that exceed the ResHab requirements.

A request for Additional Residential Supports must include documentation that the provider is providing the full amount of staffing hours already funded in the applicable Residential Habilitation rate model. The DOH/DDD review of the request will consider total staffing funded in the rates for each participant because staff hours are generally shared across residents. The provider will also submit documentation outlining the reasons for needing additional staff hours and a plan for phasing-out the extra staff hours.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The caregiver or any other member of the household is prohibited from being the provider of Additional Residential Supports.

Additional Residential Supports is limited to certified Adult Foster Homes (AFH), Developmental Disabilities

Domiciliary Homes (DD Doms), Adult Residential Care Homes (ARCH), Expanded Adult Residential Care Homes (E-ARCH), and Therapeutic Living Programs (TLP).

This service must be prior authorized by DOH/DDD based on clinical review. Redetermination of extensions to the short-term authorization shall be made on an individual basis by DOH/DDD.

Payment for services is based on compliance with billing protocols and completed supporting documentation as required by the Medicaid Waiver Standards.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Additional Residential Supports**

**Provider Category:**
Agency
**Provider Type:**
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDD
**Frequency of Verification:**

Prior to and after service delivery OR 1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Assistive Technology

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| | |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities of participants. The assistive technology must be for the use of the participant and necessary as specified in the ISP to assist the participant in achieving identified measurable goals, has high potential to increase autonomy and reduce the need for physical assistance, and is the most cost-effective option. A functional assessment must be completed by a clinician within the scope of his or her license that evaluates the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant.

Assistive technology services include:
1) assisting the participant to select, purchase, lease, or acquire assistive technology devices for participants;
2) designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices; and
3) coordinating with the DOH/DDD case manager to obtain any necessary therapies, interventions, or services with assistive technology devices.

Assessment and training related to the Assistive Technology are completed under another waiver service, Training & Consultation and are not included in this service.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Commercially-available technology such as tablets and software applications are available only for the purposes of communication if not eligible under the QUEST Integration health plan or as a job aid for employment if not eligible under the Division of Vocational Rehabilitation.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education act (20 U.S.C. 1401 et seq.) or covered under EPSDT or the State Plan through the QUEST Integration health plans or covered by other insurance. If the device would have been covered but the plan rules were not followed, the device shall not be purchased using waiver funds.

Replacement of assistive technology may be made when an assessment determines that it is more cost-effective to replace rather than repair the item and shall not occur more frequently than once a year for low-technology solutions or once every two years for customized, adapted or higher-technology devices.

The purchase, training and upkeep of service animals are excluded. Internet service, laptops, personal computers and cell phones are excluded.

Payment for services is based on compliance with billing protocols and completed supporting documentation as required by the Medicaid Waiver Standards.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement |
| Individual | Vendor |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Assistive Technology**

**Provider Category:**
Agency
**Provider Type:**
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDD

**Frequency of Verification:**
Prior to and after service delivery OR 1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Assistive Technology**

**Provider Category:**
Individual

**Provider Type:**
Vendor

**Provider Qualifications**

**License** *(specify):*
State of Hawaii Department of Commerce & Consumer Affairs, if applicable State General Excise Tax license

**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDD

**Frequency of Verification:**
Prior to and after service delivery

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Chore

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| | |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*
Chore services are needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, and moving heavy items of furniture, in order to provide safe access and egress as well as more routine or regular services such as the performance of general household tasks, e.g., meal preparation and routine household care for the participant only. These services are available to participants living independently who need Chore services and are without natural (non-paid) supports or who are living with family but the natural supports are physically unable to perform the chores. Documentation must indicate that no other party is capable of and responsible for providing chore services, including the participant, anyone else financially providing for him/her, and another relative, caregiver, landlord, community/volunteer agency, or third party payer.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Chore services are not face-to-face with the participant and may be provided at the same time (same 15-minute period) as the participant receives another waiver service.

Chore services may not be authorized for participants who live independently or with family where either the participant or natural supports are able to perform this service.

An individual serving as a designated representative for a waiver participant using the consumer-directed option may not provide Chore.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

**Service Delivery Method** *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| | |

| Provider Category | Provider Type Title |
|---|---|
| Individual | Consumer Directed Direct Support Worker (DSW) |
| Agency | DOH/DDD Waiver Provider Agency, i.e., agency with Medicaid provider agreement |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Chore**

**Provider Category:**
Individual
**Provider Type:**
Consumer Directed Direct Support Worker (DSW)
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Consumer directed – is 18 years of age or older, completes criminal history check, is able to work in the United States, and meets qualifications in job description - trained and supervised by the participant/designated representative
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Employer/Designated Representative
**Frequency of Verification:**
1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Chore**

**Provider Category:**
Agency
**Provider Type:**
DOH/DDD Waiver Provider Agency, i.e., agency with Medicaid provider agreement
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD

in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDD

**Frequency of Verification:**
1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Community Learning Services (CLS)

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 04 Day Services | 04070 community integration |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*
Community Learning Services (CLS) support the participant's integration in the community. Services will meet the participant's needs and preferences for active community participation, including the participant's choice whether to do the activity individually or with a small group of others who share that interest. The intended outcome of CLS is to improve the participant's access to the community through increasing skills, improving communication, developing and maintaining friendships, gaining experience with the opportunities available in the community each as public events and enrichment activities, functioning as independently as possible, and/or relying less on paid supports. These services assist the participant to acquire, retain, or improve social and networking skills, develop and retain social valued roles, independently use community resources, develop adaptive and leisure skills, hobbies, and exercise civil rights and self-advocacy skills required for active

community participation.

CLS is available to participants of all ages. For children, CLS is used to support the goals and outcomes identified in the ISP that involve age-appropriate activities with their peers in locations where children gather, engaging with other children with similar interests, and building relationships with peers outside of school. As children reach their teen years, CLS also includes developing and identifying interests that could lead to exploring, discovery and planning for competitive integrated employment through the Discovery and Career Planning Service.

CLS shall be delivered only in integrated settings in the community, outside the participant's place of residence or ADH setting.

CLS is identified through the person-centered planning process and included in the participant's ISP. Community Learning Services are designed to teach and coach, with a plan to fade (proximity and duration of the stuff providing the service) as appropriate for that individual and includes individualized timelines specified in the ISP as the participant gains skills, confidence and natural supports. Community Learning Services are directly linked to goals, outcomes and expectations of improving and retaining skills or opportunities for community engagement and integration. Progress towards the participant's community integration using this service will be assessed and reviewed regularly to evaluate the gains being made toward the outcomes.

These services can occur during the day, evening, and weekend, based on the choice of the participant when to use CLS.

CLS can be used by an individual for ongoing supports to volunteer at non-profit organizations or work in competitive integrated employment. The primary responsibilities of CLS staff implementing the service in these settings focus on training and assistance in activities of daily living, such as eating, toileting, mobility and transfers which would not be typically provided by co-workers or supervisors at the volunteer or work site. The determination of need for ongoing supports using CLS in volunteer settings is made based on an assessment by the DOH/DDD case manager and in work settings is made based on an assessment by the job coach, at least annually. The DOH/DDD case manager will authorize Individual Employment Supports for the job coach assessment at the work site to evaluate the ongoing need for CLS staff to support a participant in work activities. The job couach will also determine whether adding job aides, performing systematic instruction, developing natural supports with co-workers and supervisors or identifying person-specific tools and interventions that can be implemented to assist the individual with achieving the maximum level of independence possible in their work setting. The job coach may identify needs that would be better addressed through employment-related services and recommend the participant receive additional Individual Employment Supports and/or Discovery & Career Planning. The ISP must document that CLS will not duplicate other services, such as job coach under Individual Employment Supports.

Personal care/assistance may be a component part of CLS as necessary to meet the needs of a participant but may not comprise the entirety of the service.

Transportation to and from the participant's residence to the community location is provided through CLS and is included in the provider's rate paid for the service.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

An individual serving as a designated representative for a waiver participant using the consumer-directed option may not provide CLS.

CLS does not include educational services otherwise available through a program funded under section 602(16) and (17) of the Individuals with Disabilities Education Act (28 U.S.C. 1401(16 and 17)), but may complement those services beyond any program limitations.

CLS is not intended to replace the family's responsibilities for child care, after-school activities or typical family activities.

Community Learning Services-Group in combination with Adult Day Health (ADH) comprise a set of services to support participants to have a flexible mix of on-site and community-based services. The annual limit for this set of CLS-Group and ADH services is 1560 hours. The distribution of CLS-Group and ADH services within the 1560 hours will be determined through the person-centered planning process and specified in the ISP.

Requests for services in excess of 1560 hours annually are reviewed through an exception process on a case-by-case basis.

CLS most not duplicate or be provided at the same period of the day (same 15-minute period) as any other service that is being delivered face-to-face with the participant, such as Personal Assistance/Habilitation, Individual Employment Supports, Adult Day Health, Discovery & Career Planning or Respite.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver.

An assessment by a job coach is required within six months of the ISP plan year for participants who have been receiving long-term CLS (and prior to FY18, had PAB services) in order to continue authorizing the use of CLS for the purpose of employment as well as to recommend additional waiver services that would benefit the participant such as Individual Employment Supports and/or Discovery & Career Planning.

**Service Delivery Method** *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Consumer-Directed Community Learning Services Worker |
| Agency | DOH/DDD Waiver Provider Agency, i.e., agency with Medicaid provider agreement |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Community Learning Services (CLS)**

**Provider Category:**
Individual

**Provider Type:**
Consumer-Directed Community Learning Services Worker

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Consumer directed — staff must be at least 18 years of age, be able to work in the United States, completes criminal history background check, meets qualifications in job description, and is trained and supervised by the participant/designated representative

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Employer/Designated Representative

**Frequency of Verification:**

1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Community Learning Services (CLS)**

**Provider Category:**
Agency
**Provider Type:**
DOH/DDD Waiver Provider Agency, i.e., agency with Medicaid provider agreement
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, receive specialized training in community integration, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDD
**Frequency of Verification:**
1st month of service for initial evaluation and every succeeding 12th month thereafter.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Environmental Accessibility Adaptations

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope):*
Those physical adaptations permanently installed to the participant's home, required by the participant's ISP , that are necessary to ensure the health, welfare and safety of the participant and enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, environmental control devices that replace the need for physical assistance and increase the participant's ability to live independently, such as automatic door openers, or the installation of specialized electric and plumbing systems needed to accommodate the medical equipment and supplies that are necessary for the welfare of the participant and directly related to the participant's developmental disability.

Adaptations must be of direct medical or remedial benefit and not be considered experimental.

"Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the ISP and without which the participant would be at high risk of institutional or more restrictive placement. "Experimental" means that the validity of the use of the adaptation and associated equipment has not been supported in one or more studies in a refereed professional journal.

Assessment and training related to the EAA are completed under another waiver service, Training & Consultation and are not included in this service.

Adaptations are for homes owned by the participant and/or legal guardian (if applicable) or family with documentation provided to demonstrate ownership. Adaptations may be completed on a rental property where the property owner has agreed in writing to the adaptation and will not require that the property be restored to the previous floor plan or condition.

Adaptations must be ordered by a physician or other health provider with prescriptive authority under Hawaii law. The order must be dated within one year of the request.

All adaptations shall be made utilizing the most cost effective materials and supplies. The environmental modification must incorporate reasonable and necessary construction standards.

The infrastructure of the home involved in the funded adaptations (e.g., electrical system, plumbing, water/sewer, foundation, smoke detector systems, roof, free of pest damage) must be in compliance with any applicable local codes. This service shall exclude costs for improvements exclusively required to meet local building codes.

The process is the same for obtaining any environmental accessibility adaptation, whether for a first modification or if requesting an exception because of extenuating circumstances that could not be anticipated at the time the initial environmental accessibility adaptation was completed. The process begins with the person-centered planning discussion and recommendations in the ISP. A referral is made to obtain a Training & Consultation (T&C) assessment by a licensed clinician, generally an occupational therapist or physical therapist. Once the assessment and recommendations are completed, it is reviewed by a team of DOH/DDD staff. The review determines if all the necessary information has been provided for justification of medical need or if additional information is required to develop the scope of work. The scope is posted on the State of Hawaii procurement website and contractors submit bids. The bids are reviewed and an award is made. Once the work is completed, the T&C clinician that completed the initial assessment visits the home, trains the family and

participant, and signs off that the adaptation meets the individual's needs. The DOH/DDD team works closely with the case manager, unit supervisor and section supervisor to facilitate the process. If the requested adaptation does not meet medical need or waiver requirements for authorization through the waiver, the participant or legal representative, if applicable, is given a Notice of Action stating the reason for the action taken and may appeal that decision.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Environmental Accessibility Adaptations will not supplant services available through the approved Medicaid State plan under the home health benefit or the EPSDT benefit.

Limit of $55,000 per request which includes a maximum of $45,000 for the modification by the licensed building contractor and a maximum of $10,000 for the engineering or architectural drawings and permits required by the city or county where the home is located.

Requests for modifications are limited to once in the life expectancy of the modification as follows:
Grab bars – 5 years
Environmental Control Devices (automatic door opener) – 5 years
Exterior ramp – 7 years
Bathroom modification – 15 years
Widen doors and hallways – 15 years
Other modifications – determined on a case-by-case basis

A participant may request more than one modification within a 5 calendar year period but the requests must be medically necessary to address different needs, such as a ramp for access to the building and a roll-in shower for bathing.

Exceptions may be made for the health and safety of the participant, e.g., participant condition changes and needs a modification in order to remain in the community or the participant must move from a rented setting. Participants are always afforded the ability to request that DOH/DDD review the participant's situation if a modification is needed prior to the life expectancy of the modification period.

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant (carpeting; roof repair; sidewalks; driveways; garages; hot tubs; whirlpool tubs; swimming pools; landscaping; pest control; converting or updating a cesspool to a septic tank system or an aerobic treatment unit system, or connecting to a sewer system; and general home repairs and maintenance).

Cosmetic improvements are excluded. Egress is limited to one exterior door.

Additional square footage is excluded. Additional square footage means adding to the home's living area or living space that is considered "habitable space" in the building code. EAA shall not be authorized to build an extension or addition at, above or below grade on the existing structure of living area; convert and/or enclose a garage, shed, carport space, porch, lanai or other non-living space such as attic or area with sloped ceiling that does not meet minimum ceiling height requirements; or construct an ohana or accessory dwelling unit. If the homeowner builds an addition onto the home, EAA may be authorized for the modifications needed inside the new space to meet the participant's accessibility needs such as wider door or accessible shower.

Prior authorization by DOH-DDD is required based on clinical review.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Independent Contractor |
| Agency | DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Environmental Accessibility Adaptations**

**Provider Category:**
Individual

**Provider Type:**
Independent Contractor

**Provider Qualifications**

**License** *(specify):*
State of Hawaii Department of Commerce & Consumer Affairs
State General Excise Tax License
Valid General Contractor's license in the State of Hawaii

**Certificate** *(specify):*

**Other Standard** *(specify):*
Must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDD

**Frequency of Verification:**
Prior to, during and after service delivery

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Environmental Accessibility Adaptations**

**Provider Category:**
Agency

**Provider Type:**
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, and be able to perform the required

tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDD

**Frequency of Verification:**
1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Non-Medical Transportation

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| | |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*
Non-Medical Transportation is offered to enable participants to gain access to waiver services and other (non-waiver) community services, activities and resources, as specified in the Individualized Service Plan (ISP). Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, are utilized. The service may be used by a participant who lives in a rural or other area where public transportation is limited or non-existent or if the participant requires door-to-door transportation because he/she is unable to reasonably access the bus-stop or other public pick-up location. This service may be consumer-directed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The most cost-effective mode of transportation will be authorized.

This service shall not be used to provide medical transportation required under 42 CFR §431.53 and transportation services under the State plan delivered through the QUEST Integration health plans. Non-Medical Transportation Services may not duplicate transportation that is included within another waiver service or to transport the participant to a setting that is the responsibility of another agency, such as the Department of Education.

An individual serving as a designated representative for a waiver participant using the consumer-directed option may not provide Non-Medical Transportation.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

**Service Delivery Method** *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement |
| Individual | Consumer Directed Direct Support Worker (DSW) |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Non-Medical Transportation**

**Provider Category:**
Agency
**Provider Type:**
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
**Provider Qualifications**

**License** *(specify):*
Valid Driver's license
P.U.C. license as appropriate
**Certificate** *(specify):*

**Other Standard** *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

Each agency must follow P.U.C. standards, as applicable.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDD

**Frequency of Verification:**
1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Non-Medical Transportation**

**Provider Category:**
Individual

**Provider Type:**
Consumer Directed Direct Support Worker (DSW)

**Provider Qualifications**

**License** *(specify):*
Valid Hawaii Driver's License

**Certificate** *(specify):*

**Other Standard** *(specify):*
Consumer directed – is 18 years of age or older, completes criminal history check, is able to work in the United States, and meets qualifications in job description - trained and supervised by the participant/designated representative

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Employer/Designated Representative

**Frequency of Verification:**
1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Personal Emergency Response System (PERS)

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope):*
PERS is a commercially-available system that is used by members of the community, including waiver participants, who may need assistance to secure help in an emergency while maintaining independence at home.

This service must be authorized through the ISP process using a person-centered approach that documents the participant's choice to use a PERS, describes how the PERS will help the participant achieve the life he/she desires and how it will support independence. The ISP shall also document how the PERS will be used in a manner that ensures the participant's rights to privacy, dignity, respect and freedom from coercion and restraint.

As part of the system, a participant may also wear a portable "help" button. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals who attempt to contact the participant to determine the nature of the emergency and whether to call for police, fire or ambulance or to call the participant's emergency contact. The participant will select individuals who serve as emergency contacts. This list of contacts is kept on file by the PERS response center. The response center may also provide daily reminder calls to participants or respond to the fall detector alarm if the participant falls and is unable to call for help. Service includes a one-time installation fee for new systems and up to 12 months per year for on-going monitoring of the system. In the event the participant moves to a different home or apartment, a new installation fee is authorized to set up the PERS at the new location.

Assessment of the need for this service, as well as training in the use of the PERS, is included in the waiver service.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
This service is available for participants living in their own home or family home.

If a participant has a goal to move from a certified or licensed setting to their own home or family home within six (6) months, PERS may be installed at the certified or licensed setting for the participant to gain experience and skills with the PERS prior to moving out. The transition plan to move to a more independent living arrangement must be specified in the ISP.

During the trial period, the participant is encouraged to identify emergency contacts who are friends or family and not paid waiver caregivers or staff. When the participant uses the PERS to call for help, it is directly connected to the PERS response center personnel. The caregiver or staff at the certified or licensed home will assist the participant with learning how and when to activate the "help" button through the PERS response center, which is the direct contact once the alarm is activated.

At the end of the trial period, if the participant is able to use the PERS and wants the system installed in the new residence, DDD will authorize an installation at the new location. If the participant decides not to move, is unable to use the PERS or chooses not to have it installed in the new residence, the ISP will be updated to indicate the PERS is being discontinued. Any PERS equipment will be disconnected and returned to the provider.

This service shall not be used for purchasing, installing and/or monitoring any device or system that could limit the participant's rights to privacy, dignity, respect, and freedom from coercion and restraint. Prohibited systems

or devices include, but are not limited to, Global Positioning System (GPS) tracking, video cameras, or door alarms.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Personal Emergency Response System (PERS)**

**Provider Category:**
Agency

**Provider Type:**
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDD

**Frequency of Verification:**
1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Private Duty Nursing (PDN)

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| 05 Nursing | 05010 private duty nursing |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Private Duty Nursing (PDN) services are defined as services determined medically necessary to support an adult (21 years of age and older) with substantial complex health management support needs. PDN services must be specified in the ISP. PDN services are within the scope of the State's Nurse Practice Act and require the education, continuous assessment, professional judgment, nursing interventions and skilled nursing tasks of a registered nurse (RN), or licensed practical nurse (LPN) under the supervision of an RN. The RN and LPN are licensed to practice in the State of Hawaii.

PDN services are provided to participants who meet all of the following:
- require continuous but less than 24 hours-per-day nursing care on an ongoing long-term basis;
- have complex health management support needs for their medical condition based on a functional needs assessment;
- PDN services have been determined medically necessary if it is recommended by the treating physician or treating licensed health care provider and is approved by DOH/DDD; and
- require a nursing care plan that is incorporated into the Individualized Service Plan, which determines the frequency of review for continued need of this service.

The nurse provides detailed notes of interventions, judgments and assessments and makes documentation available at the frequency specified in the ISP for the DOH/DDD case manager and upon request, review by DOH/DDD and DHS/MQD.

PDN services may be provided in the participant's home or at locations in the community.

Complex means scheduled, hands-on nursing interventions. Observation in case an intervention is required is not considered complex skilled nursing and is not covered by the Medicaid I/DD Waiver as medically necessary

PDN services.

Continuous means nursing assessments requiring interventions are performed at least every two or three hours during the period PDN services are provided.

Substantial means there is a need for interrelated nursing assessments and interventions. Interventions not requiring an assessment or judgment by a licensed nurse are not considered substantial.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
PDN services are provided to participants age 21 and older up to a limit maximum of 8 hours on average per day during the authorization period. PDN services are not intended to provide all of the supports a participant requires to live at home.

PDN services must be prior authorized by DOH/DDD.

PDN cannot be provided at the same time (same 15-minute period) as another waiver service, except when the participant has been assessed to require 2:1 supports based on the results of a functional needs assessment when a) the participant requires a nurse for health care needs and a second staff performing distinct and separate duties for training in activities of daily living; or b) requires a nurse while also attending employment or adult day health activities; or c) requires a nurse while also participating in community learning activities.

The services under Private Duty Nursing are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

All medically necessary private duty nursing for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Private duty nursing in this waiver is only provided to individuals age 21 and over and only when the limits of this waiver service furnished under the approved state plan are
exhausted.

PDN services must not duplicate services available to a participant under the Medicaid State Plan, any third-party payer, a program funded through section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (30 U.S.C. 1401 et seq.).

PDN services shall not be provided during transportation to and from school or during all instruction activities specified in the Individual Education Plan.

PDN services may be provided by a qualified family member who is employed by a waiver provider or a qualified caregiver who is an independent contractor of Residential Habilitation services under a waiver provider. “Qualified” means the family member or caregiver must meets the requirements (licensed RN or LPN under the supervision of a RN).

PDN services shall not be used for respite services, companionship, or transportation to medical appointments.

PDN services shall not be authorized when the purpose of having a licensed nurse with the participant is only for observation or monitoring in case an intervention is required.

PDN services shall not be used when the nursing care activities can be delegated to qualified direct support workers.

The participant receiving PDN must also require at least one of the following habilitative services as specified in the ISP:

-Personal Assistance/Habilitation (PAB): The service must focus on a habilitative goal and outcome to improve or maintain abilities. Personal care may be a component but must not comprise the entirety of the service to meet the requirement for a habilitative service;

- Community Learning Service (CLS);

- Discovery & Career Planning;

- Individual Employment Supports; or

- Adult Day Health: The service must focus on a habilitative goal and outcome to improve or maintain abilities. Personal care/assistance may be provided when incidental to the delivery of PDN as necessary to meet the needs of a participant but may not comprise the entirety of the service.

If DOH/DDD authorizes a short-term increase above the 8 hours-per-day limit, the authorized increase shall not exceed 30 days. The DOH/DDD case manager must be notified immediately when an exception request is made for a short-term increase in PDN hours above the limit.

A participant may be eligible for a short-term increase in PDN service when he or she meets one of the following significant changes in condition:

a. participant has increased medical support needs, such as new trach or technology, immediately post discharge from hospital, to accommodate the transition and the need for training of informal caregivers. Services will generally start at a higher number of PDN hours and be reduced slowly over the course of the 30 days.

b. An acute, temporary change in condition causing increased amount and frequency of nursing interventions.

c. A family emergency or temporary inability of the informal caregiver to provide care due to illness or injury.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Private Duty Nursing (PDN)**

**Provider Category:**
Agency
**Provider Type:**
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
**Provider Qualifications**
**License** *(specify):*
Licensed Registered Nurse per Chapter 457, Hawaii Revised Statues

Licensed Practical Nurse per Chapter 457, Hawaii Revised Statues
**Certificate** *(specify):*

**Other Standard** *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to

perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State. Each agency must follow the Hawaii State Administrative Rules regarding the Hawaii Nurse Practice Act.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

DOH/DDD

**Frequency of Verification:**

1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Specialized Medical Equipment and Supplies

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| | |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Specialized medical equipment and supplies include:

1) devices, controls, appliances, equipment and supplies, specified in the plan of care, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live;

2) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

3) such other durable and non-durable medical equipment not available under the State Plan that are necessary

to address participant functional limitations; and
4) necessary medical supplies.

There must be documented evidence that the item is the most cost-effective alternative to meet the participant's need. All items must be ordered on a prescription. An order is valid one year from the date it was signed.

All items shall meet applicable standards of manufacture, design and installation.

Nutritional diet supplements, such as Ensure and Pediasure, are only covered by the waiver if the participant is able to eat by mouth (no feeding tube) and is at risk for weight loss that will adversely impact the participant's health. Prior to authorization, the plan includes a request from a medical provider and measurable weight goals and a follow-up plan.

Additional diapers, pads and gloves over the amount covered by the State Plan may be covered by the waiver only on a temporary or intermittent basis. Temporary is defined as a period of three months or less. Intermittent is defined as occurring at irregular intervals, sporadic and not continuous.

Assessment and training related to the Specialized Medical Equipment and Supplies are completed under another waiver service, Training & Consultation and are not included in this service.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Specialized Medical Equipment and Supplies under the waiver may not replace the medical supplies equipment and appliances covered by other insurances or under the State Plan through the home health benefit, including EPSDT medically necessary equipment and supplies for waiver participants under age 21. All applicable private insurance, Medicare and/or Medicaid requirements for the procurement of durable medical equipment and supplies must be followed. This service may not be used to purchase equipment or supplies that would have been covered by another program if the program's rules were followed, including using network providers that participate with that program and adhering to prior authorization requirements of that program..

Specialized Medical Equipment and Supplies exclude those items that are not of direct medical or remedial benefit to the participant or are considered to be experimental.

“Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or supply that are essential to the implementation of the ISP and without which the participant would be at high risk of institutional or more restrictive placement. "Experimental" means that the validity of the use of the adaptation and associated equipment has not been supported in one or more studies in a refereed professional journal.

Eye glasses, hearing aids, and dentures are not covered.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement |
| Agency | Medical Supply Company |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Specialized Medical Equipment and Supplies**

**Provider Category:**
Agency
**Provider Type:**
DOH/DDD Waiver Provider, i.e., agency with Medicaid provider agreement
**Provider Qualifications**
**License** *(specify):*
State of Hawaii Department of Commerce & Consumer Affairs, if applicable
**Certificate** *(specify):*

**Other Standard** *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDD
**Frequency of Verification:**
Prior to, during and after the service delivery

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Specialized Medical Equipment and Supplies**

**Provider Category:**
Agency
**Provider Type:**
Medical Supply Company
**Provider Qualifications**
**License** *(specify):*
State of Hawaii Department of Commerce & Consumer Affairs, if applicable
State General Excise Tax license
**Certificate** *(specify):*

**Other Standard** *(specify):*
Must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDD
**Frequency of Verification:**
Prior to, during and after the service delivery

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Training and Consultation

**HCBS Taxonomy:**

| **Category 1:** | **Sub-Category 1:** |
|---|---|
| | |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*

Training and consultation services assist unpaid caregivers, paid service supervisors, contractors and/or paid support staff in implementing the goals and outcomes developed from the person-centered planning process and included in the Individualized Service Plan (ISP). The goals and outcomes are necessary to improve the participant's independence and inclusion in their community. Consultation activities are provided by licensed professionals in psychology, nutrition, occupational therapy, physical therapy, speech and language pathology, behavior analysis, marriage and family therapy, clinical social work, mental health counseling and nursing.

The service may include evaluation and assessment; the development of recommendations for the goals and outcomes; training, counseling and technical assistance to implement the goals and outcomes; participating in team meetings, writing reports, and monitoring of the participant, caregivers and providers in the implementation of the goals and outcomes. This service may be delivered in the participant's home or in the community as described in the ISP.

T&C assessments and training for Assistive Technology (AT), Specialized Medical Equipment & Supplies (SMES) or Environmental Accessibility Adaptations (EAA) must be authorized separately through the ISP and are not bundled. The participant shall be offered a choice of providers and can select a different qualified provider for the assessments and/or training required to obtain the medically necessary AT, SMES or EAA. If AT, SMES and EAA assessment are completed by the same provider, they must bill each separately in accordance with the DDD prior authorization.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Training and Consultation is time limited, intermittent, and consultative. Training and consultation is not intended to provide direct services beyond the time required for the face-to-face evaluation and assessment, training, and counseling, observing/monitoring the implementation of the goals and revising/updating outcomes as appropriate.

For participants under age 21, Training and Consultation may not be delivered if such services have been determined to be medically necessary EPSDT services to be provided through the QUEST Integration health plans. This service does not supplant any service that is the responsibility of the Medicaid State Plan under the QUEST Integration health plans, another agency or other insurance.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

For AT, EAA and SMES, the T&C specialized professionals provide the assessment to determine the need for the device or modification and document the medical necessity for the participant's physician. After the device or modification has been received, the T&C specialized professional trains the participant, family and staff in the use of the device or modification.

The T&C professional must have no conflict of interest with any vendor or business that provides the AT, EAA, and SMES. SMES. All requests for AT, EAA and SMES are prior authorized by DDD. The device or modification is purchased following state of Hawaii procurement rules.

For example, a participant needs a simple AT device to remind him to take his medications and to catch the bus to work. The DDD case manager authorizes the T&C professional to assess the participant using the assigned T&C code and modifier. The T&C professional determines the medical necessity and recommends the type of AT device that will meet the need. The T&C provider bills for services using the T&C code and modifier. Once the physician prescription is obtained, the DDD will seek bids in accordance with state procurement rules and prior authorize the device using the assigned AT code and modifier for the amount of the lowest priced vendor. The vendor bills for the AT using the assigned code and modifier. The vendor or builder is only paid the amount prior authorized and there are system edits to prevent excess payments beyond the prior authorization amount. After the AT is received, the T&C professional is authorized by DDD for brief training sessions and bills under the applicable code and modifier.

A similar process is used for SMES and EAA. The T&C professional assesses the need and makes recommendations for the equipment, supply or modification to the home. The DDD prior authorizes the amount of the SMES or EAA based on the lowest bid following state of Hawaii procurement rules. The vendor or builder completes the service and then bills using the assigned code and modifier. The vendor or builder is only paid the amount prior authorized and there are system edits to prevent excess payments beyond the prior authorization amount. After the SMES or EAA is received, the T&C professional is authorized by DDD for brief training sessions and bills under the applicable code and modifier.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Independent contractor |
| Agency | DOH/DDD Waiver Provider, i.e., agency with Medicaid Provider agreement |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Training and Consultation**

**Provider Category:**
Individual

**Provider Type:**
Independent contractor

**Provider Qualifications**

**License** *(specify):*
State of Hawaii Department of Commerce & Consumer Affairs
State General Excise Tax License
All professionals meet appropriate licensing requirements

**Certificate** *(specify):*

**Other Standard** *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work
in the United States, and able to perform the assigned tasks. Each provider must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each provider must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDD

**Frequency of Verification:**
Prior to and after service delivery

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Training and Consultation**

**Provider Category:**
Agency

**Provider Type:**
DOH/DDD Waiver Provider, i.e., agency with Medicaid Provider agreement

**Provider Qualifications**

**License** *(specify):*
All professionals meet appropriate licensing requirements

**Certificate** *(specify):*

**Other Standard** *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax

license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDD

**Frequency of Verification:**
1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**
Vehicular Modifications

**HCBS Taxonomy:**

| Category 1: | Sub-Category 1: |
|---|---|
| | |
| **Category 2:** | **Sub-Category 2:** |
| | |
| **Category 3:** | **Sub-Category 3:** |
| | |
| **Category 4:** | **Sub-Category 4:** |
| | |

**Service Definition** *(Scope):*
Adaptations to a vehicle to accommodate the special needs of the participant. Vehicle adaptations are specified in the ISP as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.

The vehicle to be modified must be structurally sound, including no rust, previous accidents or flood damage.

Repairs to the conversion components of the vehicle such as the lift, tie-down or auto-docking system may be covered with documentation that the repair is the most cost-effective solution when compared with replacement or purchase of a new modification. The ISP must document that the repair will ensure that the vehicle modification continues to be the most cost-effective, safe and appropriate way to meet the participant's accessibility needs. All applicable warranty and insurance coverage must be sought and denied before paying for repairs.

Assessment of the need for this service, as well as training in the use of the Vehicular Modification, is included in this waiver service.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Modifications for a new conversion system are limited to one request every seven (7) years at a maximum cost of $36,000, inclusive of any shipping costs. The seven (7) years is counted from the date of delivery of the previous new vehicular modification for a conversion system.

The cost for a new vehicle modification conversion system will include the purchase of an extended warranty that covers repairs to the new conversion beyond the standard warranty for the 4th through 7th year after purchase. Waiver funds may be used to cover the deductible for extended warranty repairs to the conversion. The participant and family buying the vehicle must purchase an extended warranty for the vehicle as a requirement for authorizing the vehicular modification because the conversion warranty can only be purchased with the vehicle extended warranty. Waiver funds shall not be used to pay for repairs to the vehicle.

The cost of the vehicular modification may include up to $6,000 for shipping to and from another state for a vehicle purchased or owned in Hawaii with documentation that the modification cannot be completed within the state. If purchasing a new vehicle, the participant and family must consider purchasing the vehicle on the mainland so only one-way shipping is needed. One-way shipping costs will be separated and the waiver funds are only permitted for the portion of costs attributed to the conversion portion of the total shipping costs. Shipping costs for the vehicle portion are the responsibility of the participant and family. One-way shipping will be authorized unless the participant and family present documentation why the vehicle could not be purchased on the mainland and requires two-way shipping.

The participant or family must document that the vehicle is owned by the family or participant or if purchasing new, is pre-qualified for financing the vehicle.

All vehicles considered for modification must be less than five (5) years old, have less than 50,000 miles, and have no reported accidents that damaged the frame or flood damage per a CARFAX . All vehicles must be inspected prior to shipment to the mainland for modifications.

If the participant and family have not purchased a new conversion with waiver funds within the past seven years, the vehicle's ramp or lift system and/or wheelchair tie-down or docking system may be repaired one time within seven years at a maximum total cost of $10,000.00.

Vehicular Modifications must be prior authorized by DOH/DDD based on clinical review.

The following are specifically excluded:
1) adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual;
2) purchase or lease of a vehicle;
3) regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modification;and
4) modifications that are for the convenience of the caregiver/driver and are not used by the participant, such as automatic door openers and automatic starters.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Vendor |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Vehicular Modifications**

**Provider Category:**
Individual
**Provider Type:**
Vendor
**Provider Qualifications**
**License** *(specify):*
State of Hawaii Department of Consumer Affairs, if applicable
State General Excise Tax license
**Certificate** *(specify):*

**Other Standard** *(specify):*
Must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DOH/DDD
**Frequency of Verification:**
Prior to and completion of service delivery

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Waiver Emergency Services

**HCBS Taxonomy:**

**Category 1:** **Sub-Category 1:**

**Category 2:** **Sub-Category 2:**

**Category 3:** **Sub-Category 3:**

**Category 4:** **Sub-Category 4:**

**Service Definition** *(Scope):*
Waiver emergency services (outreach) shall be defined as the initial call requesting outreach and the immediate on-site crisis support for situations in which the individual's presence in their home or program is at risk due to the display of challenging behaviors that occur with intensity, duration, and frequency, that endangers his/her safety or the safety of others or that results in the destruction of property. The outreach service must be face-to-face with the participant for at least a portion of the visit. Outreach is available to waiver participants of any age.

Waiver emergency services (Out-of-Home Stabilization or OHS) shall be defined as emergency out-of-home placement of individuals in need of intensive intervention in order to avoid institutionalization or more restrictive placement and in order to return to the current or a new living situation once stable. Waiver emergency services (OHS) shall include discharge planning at the point of admission.

Out-of-Home Stabilization is focused on services for adults.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
The DOH/DDD is actively involved in the review of participants when Out-of-Home Stabilization hours reach certain thresholds.

Payment for services is based on compliance with billing protocols and completed supporting documentation is required as proof of delivery of services as required by the Medicaid Waiver Standards.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | DOH/DDD Waiver Provider; i.e, agency with Medicaid provider agreement |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Waiver Emergency Services**

**Provider Category:**
Agency
**Provider Type:**
DOH/DDD Waiver Provider; i.e, agency with Medicaid provider agreement
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Meet Standards in Provider Services Agreement, e.g., staff must be at least 18 years of age, pass criminal history check, be able to work in the United States, trained in the ISP/IP and be able to perform the assigned tasks. Each provider agency must be approved by DOH/DDD and DHS/MQD in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA); possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET). Each agency must be able to enter into contracts with the State.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
DOH/DDD

**Frequency of Verification:**
1st month of service for initial evaluation and every succeeding 12th month thereafter

## Appendix C: Participant Services

### C-1: Summary of Services Covered (2 of 2)

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☑ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

State Department of Health, Developmental Disabilities Division Case Managers

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

a) all service supervisors (SS) and direct support workers (DSW) employed through an agency or individual providers (independent contractors)
b) state and federal
c) Provider agencies must obtain background checks from the Criminal History Data Center (CHDC) which is part of the State's Department of the Attorney General. The background check must be stamped "certified". The CHDC performs a screen match of the providers' fingerprints and name against both the FBI and State of Hawaii database for criminal activity. The provider must obtain the CHDC check before the employee is allowed to provide services to DD/ID waiver participants or within five (5) calendar days of initial hire and then within 12 months of initial CHDC check. The provider performs the name checks bi-annually thereafter.

DOH/DDD monitors to ensure compliance by checking employee records to verify that background checks have been completed. Quarterly provider reports on the status of clearances are sent to DHS/MQD by the DOH/DDD. Clearances are required initially, annually for the first year of employment, and every other year thereafter (see table attached). If the worker has not received initial clearance, the worker cannot provide waiver services. If DOH/DDD finds the agency in non-compliance, DOH/DDD requires the agency to obtain required checks within a specified time limit. If the agency refuses to comply, DOH/DDD will suspend or terminate the agency.

**b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) Fieldprint, an entity contracted by several agencies in the State of Hawaii Department of Human Services
b) all service supervisors (SS) and direct support workers (DSW) employed through an agency
c) Provider agencies complete Adult Protective Services (APS)/Child Protective Services (CPS) background checks and fingerprinting as specified in the provider agreements.

DOH/DDD staff monitors and checks agency records annually to ensure that mandatory screenings have been conducted. DOH/DDD submits quarterly reports to DHS/MQD for review.

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

**c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- ○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

**i. Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

| Facility Type | |
|---|---|
| Adult Foster Home | |
| Special Treatment Facility/Transitional Living Program | |

| Facility Type | |
|---|---|
| Developmental Disabilities Domiciliary Home | |
| Expanded Adult Residential Care Home | |
| Adult Residential Care Home | |

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Required information is contained in response to C-5

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Adult Foster Home

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|---|---|
| Skilled Nursing | ☑ |
| Community Learning Services (CLS) | ☑ |
| Training and Consultation | ☑ |
| Individual Employment Supports | ☐ |
| Private Duty Nursing (PDN) | ☐ |
| Vehicular Modifications | ☐ |
| Chore | ☐ |
| Specialized Medical Equipment and Supplies | ☑ |
| Personal Assistance/Habilitation (PAB) | ☑ |
| Adult Day Health (ADH) | ☐ |
| Additional Residential Supports | ☑ |
| Personal Emergency Response System (PERS) | ☐ |
| Respite | ☑ |
| Discovery & Career Planning (DCP) | ☐ |
| Non-Medical Transportation | ☐ |
| Residential Habilitation (ResHab) | ☑ |
| Environmental Accessibility Adaptations | ☐ |
| Waiver Emergency Services | ☑ |
| Assistive Technology | ☑ |

**Facility Capacity Limit:**

2

**Scope of Facility Sandards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

**Scope of State Facility Standards**

| Standard | Topic Addressed |
|---|---|
| Admission policies | ☑ |
| Physical environment | ☑ |
| Sanitation | ☑ |
| Safety | ☑ |
| Staff : resident ratios | ☑ |
| Staff training and qualifications | ☑ |
| Staff supervision | ☑ |
| Resident rights | ☑ |
| Medication administration | ☑ |
| Use of restrictive interventions | ☑ |
| Incident reporting | ☑ |
| Provision of or arrangement for necessary health services | ☑ |

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Special Treatment Facility/Transitional Living Program

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|---|---|
| **Skilled Nursing** | ☐ |
| **Community Learning Services (CLS)** | ☑ |
| **Training and Consultation** | ☐ |
| **Individual Employment Supports** | ☐ |
| **Private Duty Nursing (PDN)** | ☐ |
| **Vehicular Modifications** | ☐ |
| **Chore** | ☐ |
| **Specialized Medical Equipment and Supplies** | ☑ |
| **Personal Assistance/Habilitation (PAB)** | ☑ |
| **Adult Day Health (ADH)** | ☐ |
| **Additional Residential Supports** | ☑ |
| **Personal Emergency Response System (PERS)** | ☐ |

| Waiver Service | Provided in Facility |
|---|---|
| **Respite** | ☐ |
| **Discovery & Career Planning (DCP)** | ☐ |
| **Non-Medical Transportation** | ☐ |
| **Residential Habilitation (ResHab)** | ☑ |
| **Environmental Accessibility Adaptations** | ☐ |
| **Waiver Emergency Services** | ☑ |
| **Assistive Technology** | ☑ |

**Facility Capacity Limit:**

1-5 participants

**Scope of Facility Sandards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

**Scope of State Facility Standards**

| Standard | Topic Addressed |
|---|---|
| Admission policies | ☑ |
| Physical environment | ☑ |
| Sanitation | ☑ |
| Safety | ☑ |
| Staff : resident ratios | ☑ |
| Staff training and qualifications | ☑ |
| Staff supervision | ☑ |
| Resident rights | ☑ |
| Medication administration | ☑ |
| Use of restrictive interventions | ☑ |
| Incident reporting | ☑ |
| Provision of or arrangement for necessary health services | ☑ |

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Developmental Disabilities Domiciliary Home

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|---|---|
| **Skilled Nursing** | ☐ |

| Waiver Service | Provided in Facility |
|---|---|
| **Community Learning Services (CLS)** | ☑ |
| **Training and Consultation** | ☑ |
| **Individual Employment Supports** | ☐ |
| **Private Duty Nursing (PDN)** | ☐ |
| **Vehicular Modifications** | ☐ |
| **Chore** | ☐ |
| **Specialized Medical Equipment and Supplies** | ☑ |
| **Personal Assistance/Habilitation (PAB)** | ☑ |
| **Adult Day Health (ADH)** | ☐ |
| **Additional Residential Supports** | ☑ |
| **Personal Emergency Response System (PERS)** | ☐ |
| **Respite** | ☑ |
| **Discovery & Career Planning (DCP)** | ☐ |
| **Non-Medical Transportation** | ☐ |
| **Residential Habilitation (ResHab)** | ☑ |
| **Environmental Accessibility Adaptations** | ☐ |
| **Waiver Emergency Services** | ☑ |
| **Assistive Technology** | ☑ |

**Facility Capacity Limit:**

5

**Scope of Facility Sandards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

**Scope of State Facility Standards**

| Standard | Topic Addressed |
|---|---|
| Admission policies | ☑ |
| Physical environment | ☑ |
| Sanitation | ☑ |
| Safety | ☑ |
| Staff : resident ratios | ☑ |
| Staff training and qualifications | ☑ |
| Staff supervision | ☑ |
| Resident rights | ☑ |
| Medication administration | ☑ |
| Use of restrictive interventions | ☑ |
| Incident reporting | ☑ |
| Provision of or arrangement for necessary health services | ☑ |

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Expanded Adult Residential Care Home

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|---|---|
| Skilled Nursing | ☐ |
| Community Learning Services (CLS) | ☑ |
| Training and Consultation | ☑ |
| Individual Employment Supports | ☐ |
| Private Duty Nursing (PDN) | ☐ |
| Vehicular Modifications | ☐ |
| Chore | ☐ |
| Specialized Medical Equipment and Supplies | ☑ |
| Personal Assistance/Habilitation (PAB) | ☑ |
| Adult Day Health (ADH) | ☐ |
| Additional Residential Supports | ☑ |
| Personal Emergency Response System (PERS) | ☐ |
| Respite | ☑ |
| Discovery & Career Planning (DCP) | ☐ |
| Non-Medical Transportation | ☐ |
| Residential Habilitation (ResHab) | ☑ |
| Environmental Accessibility Adaptations | ☐ |
| Waiver Emergency Services | ☑ |
| Assistive Technology | ☑ |

**Facility Capacity Limit:**

2 E-ARCH level participants

**Scope of Facility Sandards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

**Scope of State Facility Standards**

| Standard | Topic Addressed |
|---|---|
| Admission policies | ☑ |

| Standard | Topic Addressed |
|---|---|
| Physical environment | ☑ |
| Sanitation | ☑ |
| Safety | ☑ |
| Staff : resident ratios | ☑ |
| Staff training and qualifications | ☑ |
| Staff supervision | ☑ |
| Resident rights | ☑ |
| Medication administration | ☑ |
| Use of restrictive interventions | ☑ |
| Incident reporting | ☑ |
| Provision of or arrangement for necessary health services | ☑ |

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Adult Residential Care Home

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|---|---|
| **Skilled Nursing** | ☐ |
| **Community Learning Services (CLS)** | ☑ |
| **Training and Consultation** | ☑ |
| **Individual Employment Supports** | ☐ |
| **Private Duty Nursing (PDN)** | ☐ |
| **Vehicular Modifications** | ☐ |
| **Chore** | ☐ |
| **Specialized Medical Equipment and Supplies** | ☑ |
| **Personal Assistance/Habilitation (PAB)** | ☑ |
| **Adult Day Health (ADH)** | ☐ |
| **Additional Residential Supports** | ☑ |
| **Personal Emergency Response System (PERS)** | ☐ |
| **Respite** | ☐ |
| **Discovery & Career Planning (DCP)** | ☐ |
| **Non-Medical Transportation** | ☐ |

| Waiver Service | Provided in Facility |
|---|---|
| Residential Habilitation (ResHab) | ☑ |
| Environmental Accessibility Adaptations | ☐ |
| Waiver Emergency Services | ☑ |
| Assistive Technology | ☑ |

**Facility Capacity Limit:**

Type 1 (1-5) and Type 2 (6+)

**Scope of Facility Sandards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

**Scope of State Facility Standards**

| Standard | Topic Addressed |
|---|---|
| Admission policies | ☑ |
| Physical environment | ☑ |
| Sanitation | ☑ |
| Safety | ☑ |
| Staff : resident ratios | ☑ |
| Staff training and qualifications | ☑ |
| Staff supervision | ☑ |
| Resident rights | ☑ |
| Medication administration | ☑ |
| Use of restrictive interventions | ☑ |
| Incident reporting | ☑ |
| Provision of or arrangement for necessary health services | ☑ |

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ◉ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

☐ **Self-directed**

☐ **Agency-operated**

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

◉ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Services provided are authorized based on person centered planning. The services are identified before the provider is selected.

Parents and legal guardians (if applicable) of minor children are not paid to provide services.

Relatives or family members who may provide waiver services to minor participants are defined as natural or hanai (Hawaiian tradition of taking in and caring for an individual without going through formal adoption procedures) brother, sister, aunt, uncle, cousin, grandfather or grandmother.

Spouses of participants are not paid to provide services.

Relatives or family members who may provide waiver services to adult participants are defined as natural, adoptive, step, in-law, or hanai father, mother, brother, or sister, son or daughter, and grandfather or grandmother. Guidelines for authorizing waiver services which may be provided by a family member include:
1) the family member is unable to provide the service(s) without reimbursement; and
2) the family member is the most qualified provider; or
3) the family member is the only available provider of care.

Relatives/legal guardians employed through provider agencies or relatives employed through the consumer directed model are subject to the same monitoring and supervision requirements as non-relatives/non-legal guardians.

Under the consumer directed model, a legal guardian for a participant may not hire himself or herself to provide the services for which he or she serves as the designated representative.

○ **Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Providers are enrolled on an ongoing basis. There are no enrollment period restrictions. Application packets are sent to interested persons upon request which includes information on provider requirements and the process.

Applicants that are determined to not be qualified to enroll are required to wait six (6) months and receive provider training prior to re-submitting an application.

All providers may be authorized to deliver one or more waiver services based on their ability to meet provider qualifications.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Qualified Providers**

***The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.***

**i. Sub-Assurances:**

**a.** ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% of new direct support workers (DSWs) that passed the criminal history record and abuse registry checks prior to service delivery N: # of new DSWs that passed the criminal history record and abuse registry checks prior to service delivery D: Total # of new DSWs in the sample**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**QA/QI Review of Hawaii's DD/ID Waiver Providers**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**

**#/% of new direct support workers (DSW) that passed the criminal history record and abuse registry checks prior to service delivery validated by DHS/MQD N: # of new direct support workers (DSW) that passed the criminal history record and abuse registry checks prior to service delivery validated by DHS/MQD D: Total # of new direct support workers (DSW) records reviewed by DHS/MQD**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Provider on-site reviews**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☑ **Other** Specify: Validation record review |
| | ☑ **Other** Specify: Semi-annually | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Semi-annually |

**Performance Measure:**
**#/% of participant records that meet State standards N: # of participant records that meet State standards D: Total # of applicable participant records in the sample**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**QA/QI Review of Hawaii's DD/ID Waiver Providers**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#/% of participant records that meet State standards and validated by DHS/MQD**
**N: # of participant records that meet State standards and validated by DHS/MQD**
**D: Total # of participant records reviewed by DHS/MQD**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Provider on-site reviews**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☑ **Other**<br>Specify: Validation record review |
| | ☑ **Other** | |

| | | |
|---|---|---|
| | Specify:<br>Semi-annually | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Validation record review |

**b.** ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% of non-licensed/non-certified providers/consumer directed providers that meet waiver requirements. N: # of non-licensed/non-certified/consumer directed providers that meet waiver requirements D: Total # of non-licensed/non-certified/consumer directed providers sampled**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**QA/QI Review for Case Management Services**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |

| | | |
|---|---|---|
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**#/% of non-licensed/non-certified providers/consumer directed providers that meet waiver requirements and validated by DHS/MQD. N: # of records validated by DHS/MQD D: Total # of records reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record review**

| **Responsible Party for data** | | **Sampling Approach** *(check each that applies):* |
|---|---|---|

| **collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☑ **Other** Specify: Validation record review |
| | ☑ **Other** Specify: Semi-annually | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other** Specify: Semi-annually |

**c.** ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% of new direct support workers (DSWs) that completed the required training prior to service delivery N: # of new DSWs that completed the required training prior to service delivery D: Total # of new DSWs**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**QA/QI Review of Hawaii's DD/ID Waiver Providers**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#/% of new direct support workers (DSWs) that completed the required training prior to service delivery and validated by DHS/MQD N: # of records validated by DHS/MQD D: Total # of records reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record review**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☑ **Other**<br>Specify: Validation record review |
| | ☑ **Other** | |

| | | |
|---|---|---|
| | Specify:<br>Semi-annually | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Semi-annually |

**Performance Measure:**
**#/% of non-licensed/non-certified providers/consumer directed providers that meet training requirements. N: # of non-licensed/non-certified/consumer directed providers sampled that meet training requirements D: Total # of non-licensed/non-certified/consumer directed providers sampled**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**QA/QI Review for Case Management Services**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | | ☐ **Other** |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**#/% of non-licensed/non-certified providers/consumer directed providers that meet training requirements and validated by DHS/MQD N: # of records validated by DHS/MQD D: Total # of records reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record Review**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |

| | | |
|---|---|---|
| | | |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☑ **Other**<br>Specify: Validation record review |
| | ☑ **Other**<br>Specify: Semi-annually | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify: Semi-annually |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DOH/DDD performs annual on-site reviews of licensed/certified providers to verify that providers meet waiver requirements. For non-licensed/non-certified consumer/consumer directed providers, DOH/DDD gathers information on compliance as part of their QA/QI Review for Case Management Services. If a provider is non-compliant with waiver requirements, e.g. agency personnel did not receive required training from the provider agency, DOH/DDD is responsible to ensure that the agency provides the training and to track and document this when completed. DOH/DDD in consultation with DHS/MQD may issue appropriate

sanctions to the provider for the period of non-compliance e.g., recoupment of billed services, suspension of services, termination. Results of the on-site and record reviews are submitted to DHS/MQD quarterly. DHS/MQD accompanies DOH/DDD on a sample of on-site reviews.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other** Specify: Semi-annually |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e)

the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
*Furnish the information specified above.*

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
*Furnish the information specified above.*

☑ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
*Furnish the information specified above.*

Hawaii's initiative to transform system practices is called Possibilities Now! It reflects the core values of personal choice, community inclusion, and control and responsibility over the personal supports budget. With the introduction of Supports Budgets, participants will receive a prospective budget that reflect their needs, and will be empowered to make decisions about how to use their budget to access the supports that best meet their unique circumstances.

A participant's Supports Budget is determined by their assessed needs and type of living arrangement.

There are three types of living arrangements:
1) living in a licensed or certified setting
2) living in a family setting
3) living in own home

Participants are assigned to one of seven support 'levels' based on the Supports Intensity Scale for Adults (SIS-A™). The SIS-A™ was developed by the American Association on Intellectual and Developmental Disabilities (AAIDD) to objectively measure individual supports needs. The SIS-A™ is a valid and reliable instrument for assessing the level of an individual's supports needs in major domains of daily living. Additionally, DOH/DDD has adopted a series of supplemental questions to identify extraordinary behavioral and medical support needs. Brief descriptions of the seven levels are:
- Level 1: Low support needs
- Level 2: Low to moderate support needs
- Level 3: Moderate support needs plus some behavior challenges
- Level 4: Moderate to high support needs
- Level 5: Maximum support needs
- Level 6: Significant support needs due to medical challenges
- Level 7: Significant support needs due to behavioral challenges

The principles of the system are:
- Supportive: Allocate Supports Budgets so that participants get what they need in the most independent and integrated manner
- Person-Centered: Empower participants to make decisions regarding the types of supports that best reflect their strengths, needs, and interests
- Equity: participants with similar needs receive the same allocation in Supports Budgets
- Data-Driven: Supports Budgets are based on historical service utilization

During Year 3 of the waiver renewal (state fiscal year 2019), DOH/DDD will phase-in the use of the Supports Budget, with a plan to transition all participants age 18 years and older by the end of the current waiver (by June 30, 2021). Participants will transition at their annual ISP year based on the following phase-in schedule:

Cohort 1 includes participants living in licensed or certified settings and will transition to the Supports Budget at their annual ISP year during state fiscal year 2019 (beginning July 1, 2018)

Cohort 2 includes participants living in other settings (either family or own home) and receiving Adult Day Health services. Cohort 2 will transition to the Supports Budget at their annual ISP year during state fiscal year 2020 (beginning July 1, 2019)

Cohort 3 includes participants living independently or in family homes and not receiving Adult Day Health services. Participants will transition to the Supports Budget at their annual ISP year during state fiscal year 2021 (beginning July 1, 2020)

Children under age 18 years are not subject to the Supports Budget. Services for children continue to be determined through the ISP using the current process for authorizing services.

(a) The following services are subject to the Supports Budget:
- Adult Day Health
- Community Learning Service – Group
- Community Learning Service - Individual
- Personal Assistance/Habilitation (not applicable for participants in licensed or certified settings)
- Chore (not applicable for participants in licensed or certified settings)
- Respite (only applicable for participants living in a family home)

All other services may be authorized in addition to the limit established by a participant's Supports Budget subject to determination of service necessity, applicable service limits, and authorization requirements.

Annual Supports Budgets reflect a range within which most participants' authorizations are anticipated to fall, with the top of the range representing the applicable budget limits. These ranges are specified below. The different Supports Budget ranges for participants on the Big Island account for rate differentials on that island (that is, the higher Supports Budget limits on the Big Island ensure that these participants can access an equivalent amount of service as participants on the other islands).

LIVING IN LICENSED OR CERTIFIED SETTING
Level 1: $15,938 - $21,250 ($18,555 - $24,740 on the Big Island)
Level 2: $16,938 - $22,584 ($19,698 - $26,264 on the Big Island)
Level 3: $21,326 - $28,434 ($24,588 - $32,784 on the Big Island)
Level 4: $21,326 - $28,434 ($24,588 - $32,784on the Big Island)
Level 5: $24,477 - $32,636 ($27,971 - $37,294 on the Big Island)
Level 6: $25,260 - $33,680 ($28,652 - $38,202 on the Big Island)
Level 7: $26,055 - $34,740 ($29,736 - $39,648 on the Big Island)

LIVING IN A FAMILY SETTING
Level 1: $30,041 - $40,054 ($34,465 - $45,953 on the Big Island)
Level 2: $40,941 - $54,588 ($47,075 - $62,766 on the Big Island)
Level 3: $49,698 - $66,264 ($56,951 - $75,934 on the Big Island)
Level 4: $55,293 - $73,724 ($63,431 - $84,574 on the Big Island)
Level 5: $74,384 - $99,178 ($85,255 - $113,673 on the Big Island)
Level 6: $86,070 - $114,760 ($97,742 - $130,322 on the Big Island)
Level 7: $86,811 - $115,748 ($99,130 - $132,174 on the Big Island)

LIVING IN OWN HOME
Level 1: $34,754 - $46,338 ($40,887 - $54,516 on the Big Island)
Level 2: $43,587 - $58,116 ($51,102 - $68,136 on the Big Island)
Level 3: $50,885 - $67,846 ($59,508 - $79,344 on the Big Island)

Participants living in their own home and assigned to Levels 4 through 7 will receive an individualized review to determine their Supports Budget.

(b) The Supports Budget limits were established based on analyses of historical utilization patterns as well as a validation study to test Support Budgets and confirm service mixes based on case file reviews.

DOH/DDD first considered current utilization patterns based on participants' assessed needs and residential placements. DOH/DDD began administration of the SIS-A™ in state fiscal year 2016. Assessments were administered to 565 participants ages 18 years and older selected as part of a stratified random sample. Assisted by consultants from the Human Services Research Institute (HSRI) and Burns & Associates, Inc. (B&A) DOH/DDD adopted a seven-level system that groups together individuals with comparable needs.

Paid claims for state fiscal year 2016 were compiled for participants in the sample. Based on this analysis of current utilization, DOH/DDD constructed model service mixes that reflect the amount of supports used by the large majority of participants in each assessment level and residential placement.

In September 2017, a validation study was conducted by a team of DDD and MQD staff, HSRI, a family member/ Hawaii State Council on Developmental Disabilities (DD Council) board member (DD Council), a representative from the state's University Center for Excellence in Developmental Disabilities (UCEDD) and a DD Council staff member. The purpose of the validation study was to determine whether the Supports Budget to which individual participants would be assigned based on their assessed needs and residential placement were reflective of their needs. The validation sample consisted of 102 cases. The result of the validation process determined that the proposed service packages to be adequate or more than adequate for 90% of the cases reviewed. Based on the results of the validation study, DOH/DDD made minor adjustments to several of the Supports Budgets.

(c) DOH/DDD, with assistance from HRSI and B&A, will continue to analyze service authorization and service utilization data as the expanded service array and new fee schedule are implemented. If trends depart substantially from historical patterns, DOH/DDD will consider adjustments to the Supports Budget amounts. In addition, DOH/DDD will collect and analyze data related to requests for exceptions as each cohort phases into the Supports Budgets to identify any trends that suggest the need for adjustments to the Supports Budgets. Where data demonstrates the need to adjust the Supports Budgets, an amendment will be submitted to CMS prior to implementation.

(d) It is recognized that while participants who are grouped in a certain level have similar support needs, each person is unique. Therefore, some participants may require supports above and beyond those permitted by their Supports Budget. Requests for adjustments or exceptions to the limits must be reviewed by DOH/DDD. Modifications may be made
- for reasons of health and safety,
- to permit additional time to make support adjustments (such as the development of natural/community supports) for those who are current waiver participants, or
- to provide increased services to ensure successful transition into less restricted settings, which over time will require a less intense level of support.

In certain circumstances, particularly for participants who require the highest level of supports for medical or behavioral reasons (i.e., Levels 6 and 7), an exception process will be developed and implemented to determine the supports budget. DOH/DDD will also review requested exceptions to individuals' Supports Budgets. Participants who are denied requested modifications/exceptions will be informed of the right to a Medicaid fair hearing.

(e) DOH/DDD will review requests on a case-by-case basis where the case manager identifies a concern that the Supports Budget is insufficient to meet the participant's needs. During the review process, services will not be reduced. All participants are informed of the right to Medicaid fair hearing if the exception request is denied.

(f) The proposed Supports Budget process is included in the waiver amendment, which will be posted to the DHS/MQD and DOH/DDD websites for public comment starting on December 18, 2017. The public comment period to submit feedback on the waiver amendment, which includes the new Supports Budget

process, will be approximately seven weeks, through February 2, 2018. DOH/DDD has a dedicated email for public comments, as well as other methods for members of the public to provide input.

Participants and their families will be notified by the case manager of the Supports Budget based on the participant's level of support need and type of living arrangement. This information will be provided prior to the Individualized Service Plan meeting.

☑ **Other Type of Limit.** The State employs another type of limit.

*Describe the limit and furnish the information specified above.*

Requirements for in-state and out-of-state provision of services:

a) all waiver services, with the exception of Personal Assistance/Habilitation (PAB) and consumer-directed PAB (CD PAB), must be provided in-state only. PAB and CD PAB are the only services that can be provided out-of-state within the United States. No waiver services shall be provided out of the country;

b) based on historical utilization patterns, a typical request for vacation out-of-state is 10 to 14 days annually. The 14-day limit for out-of-state vacations has been in effect for a number of years. An exception process exists if an emergency situation were to arise during the participant's travel;
i) an updated ISP action plan identifying the travel out-of-state shall be completed and signed by the participant or guardian (if applicable), waiver provider, and DOH/DDD case manager. The participant or guardian has identified a back-up plan for assuring the PAB staff hours per week do not exceed what is assessed in the current ISP action plan. Except for unforeseeable emergency situations, the participant or guardian uses the back-up plan to ensure that the participant's needs can be met within the authorized days and hours;
ii) the participant's PAB worker accompanies the participant and provides the service. The DOH/DDD does not pay for any of the travel costs or accommodations for the participant and the PAB worker;

c) unless the DOH/DDD identifies situations that require changes to the limit, the DOH/DDD does not anticipate adjusting the limit;

d) for any emergency situation in order to safeguard the health and welfare of the participant, the DOH/DDD administration shall assess the need for an increase in PAB services on a case-by-case basis. Participants who may require medical treatment out-of-state shall be referred to the QUEST Integrated Medicaid Health Plans;

e) participants and their family or guardians (if applicable) are able to contact their case managers to explain unusual or unexpected situations that require authorization of out-of-state services. As noted in (d), services may be authorized above the limit by certain individuals within the organization; and

f) participants are notified that all services, except for PAB, must be provided in-state when they are accepted into the waiver program. The providers are aware of the requirement as it is written in the Medicaid Waiver Standards.

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

See Attachment #2

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (1 of 8)

**State Participant-Centered Service Plan Title:**
Individualized Service Plan

**a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [x] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [ ] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [x] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

Case managers must meet the qualifications of either social worker, human services professional, or registered professional nurse licensed to practice in the state.

Social Workers (SW) are those with a Master's in Social Work (MSW) or a Bachelor's in Social Work (BSW) from a program of study accredited by the Council on Social Work Education, or a doctorate degree in social work from a college or university accredited by the Western Association of Schools and Colleges, or a comparable regional accreditation body. A SW with a bachelor's degree must have minimally one (1) year of progressively responsible professional work experience in a social/human/health service type of setting.

Minimum qualification requirements for Human Service Professional (HSP) is graduation from an accredited four (4) year college or university with a bachelor's degree which included a minimum of 12 semester credit hours in courses such as counseling, criminal justice, human services, psychology, social work, social welfare, sociology or other behavioral sciences. The HSP must also have minimally 1.5 years of progressively responsible professional work experience in a social/human/health service type of setting.

SW and HSP workers are also trained in the DOH/DDD branch policies and procedures as related to service plan development.

- [ ] **Social Worker**

*Specify qualifications:*

- [ ] **Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

**b. Service Plan Development Safeguards.** *Select one:*

- (•) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (3 of 8)

**c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

a) The person-centered planning process is driven by the participant who is the center of the planning process. Hawaii Revised Statutes (HRS) chapter 333F governing services for people with developmental disabilities and/or intellectual disabilities provides the statutory mandates for person-centered planning and self-determination. HRS § 333F-1 defines the individualized service plan (ISP) as the "written plan required by HRS § 333F-6 that is developed by the individual, with the input of family, friends, and other persons identified by the individual as being important to the planning process." The person- centered process provides necessary information and support to the participant to ensure that the individual directs and facilitates the process to the maximum extent possible.

b) Participants receive information regarding person-centered planning in both written and oral formats. Family members receive "A Guide to Person-Centered Planning" brochure that includes self-determination principles.

A Case Management Branch (CMB) brochure outlines the supports and services funded by Department of Health, Developmental Disabilities Division (DOH/DDD). Participants also receive the "Home and Community Based Services (HCBS) for persons with developmental disabilities Medicaid Waiver Program" brochure, which provides information on eligibility and services offered under the HCBS waiver.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) The ISP is the written plan required by HRS § 333F-6. The DOH/DDD case manager assists the participant to develop the ISP, with the input of the circle of support, family, friends, and other persons chosen by the participant as being important to the planning process. The "circle of supports" may include parents, guardians (if applicable), siblings, friends, paid and unpaid supports, service provider(s) and the DHS QUEST Integration (QI) service coordinator. An ISP is initiated after eligibility for services is determined by the DOH/DDD. The ISP is reviewed/updated prior to being admitted into the waiver, and annually thereafter.The actual ISP meeting shall occur at times and locations of convenience to the participant. Prior to the ISP meeting the DOH/DDD case manager contacts the participant and/or guardian to ask them about their available time and location preferences.

b) Assessment information is gathered by qualified DOH/DDD staff and the participant directly through interviews and direct observation. Information is also obtained from persons who know the participant well, such as family members, guardians (if applicable), friends, residential providers, service providers and health professionals. Types of assessments used by the DOH/DDD case managers include:

i) a service planning assessment, e.g. the Inventory for Client and Agency Planning (ICAP) or the Supports Intensity Scale for Adults (SIS-A) conducted by qualified DOH/DDD staff identifies the participant's areas of support needs,

relative strengths and challenges, as well as medical and/or behavioral concerns.

In FY2018, DOH/DDD began implementing the Supports Intensity Scale for Adults (SIS-A™) assessments for participants age 16 and older. It is being used to inform ISPs based on the level of support needs identified through the SIS-A™. The SIS-A™ measures the frequency, type, and duration of support that participants require in order to take part in activities of everyday life, as well as exceptional medical and behavioral support needs.

Participants will be assessed using the SIS-A™ every three years. To produce a reasonably consistent assessment schedule over that three-year cycle, DOH/DDD has divided waiver participants into three cohorts based on residential placement and services used. Participants receiving daily residential care in licensed and certified homes will be assessed using the SIS-A™ in the first year of the phase-in (Cohort 1), followed by participants receiving Adult Day Health services in the second year of the phase-in (Cohort 2), and by all other participants who receive daily residential care or ADH services. SIS-A™ assessment results will be available for the first cohort for Individualized Service Plans (ISP) effective on or after July 1, 2017, for the second cohort for ISP on or after July 1, 2018, and for the third cohort for ISP on or after July 1, 2019.

Starting in FY2019, DOH/DDD will begin phase-in of the Supports Budgets that are based on the SIS-A™ level of supports needs for a mix of services. The phase-in schedule will use the same cohorts described in the previous paragraph with Cohort 1 transitioning to use of Supports Budgets in FY2019 with their ISP on and after July 1, 2018; Cohort 2 will transition to use of Supports Budgets in FY2020 with their ISP on and after July 1, 2019; and Cohort 3 will transition to use of Supports Budgets in FY2021 with their ISP on and after July 1, 2020.

ii) prior to the ISP, the DOH/DDD case manager, identifies the participant's circle with the participant and/or guardian (if applicable) to include other supporting agencies. The DOH/DDD case manager with the participant and /or guardian obtains information on the following sections of the ISP: person-centered planning preferences, This is Who I Am, How I communicate, What's Important and Meaningful to Me; and "My Information", which documents "My Health" (includes clinical and support needs, diagnosis/medical conditions, allergies, medications and health supports), behavioral supports, emergency and crisis planning, and disaster preparedness, as applicable.

c) Participants are informed of services available through the waiver in a variety of ways; prior to each DOH/DDD intake, and again at each annual ISP meeting. The DOH/DDD case manager provides and makes available and reviews the following:

i) the HCBS brochure, which lists the waiver services, eligibility criteria, other available services, and the process and timelines for admission into the waiver program;

ii) the Medicaid Waiver Providers in Hawaii booklet, which lists the services and the agencies that provide each service, including the geographic areas served by each agency. The booklet also contains questions the participant and/or legal guardian (if applicable) may want to ask the potential provider agency to help with service and agency choices. The booklet is updated periodically to reflect changes in waiver services and provider agencies; and

iii) the Consumer Directed (CD) Services brochure, which describes the consumer directed option for self-directed services.

The DOH/DDD provides outreach and informational sessions to various community groups, e.g. the Department of Education (DOE), job and transition fairs, conferences and other venues to provide information on available programs and services through the HCBS waiver.

The DOH also has a website describing waiver services.

d) The ISP shall be a written description of what is important to the participant to ensure delivery of services in a manner reflecting personal preferences, how any issues of health and safety shall be addressed, and what needs to happen to support the participant in his/her desired life. The ISP identifies the strengths, needs (clinical and support), and desired outcomes of the participant to also include:

i) how the participant communicates; (e.g. primary language, through gesturing, communicative devices, sign language, etc.);

ii) based on input from the DOH/DDD self-advocates, the following are included within the What's Important and

Meaningful to Me section of the ISP; where the participant wants to live and with whom, health supports, well-being, safety supports, employment preferences, learning new things, relationships, leisure and recreation, what things the participant does not want in his/her life, opportunities to engage and receive services in the community, having the control of personal resources and other significant interests and preferences as identified by the participant (e.g. cultural, spiritual, religious traditions/celebrations, etc.);

iii) a discussion with the participant, guardian (if applicable) and circle of support regarding written information from the participant's medical, waiver provider and specialty medical reports. Other documents used include the case management assessments, and other reports (e.g. speech, occupational, educational, etc.) that will be integrated into the participant's individualized service plan as agreed upon by the participant and guardian (if applicable);

iv) SIS assessment results will be available to the planning team and will complement other information about the participant and their strengths, desires, and goals. Information from the SIS – which includes insights into the supports that the participant needs in various facets of their life, comparative data that illustrates the areas in which relatively more or fewer supports are needed as well as how the participant compares to the general population of persons with intellectual and developmental disabilities, and the participant's 'level' assignment for services with needs-based rate categories – will assist the team in the determination of the types and amounts of supports that participants require. While SIS assessment results will establish some parameters for the participant's services (for example, by assigning the rate category for certain services), the assessment does not dictate the person-centered planning process or the resultant service plan.

v) priority goals and outcomes based on the participant's personal preferences, related to relationships, community participation, employment income and savings, healthcare and wellness. Interviews are also completed with the participant to identify other choices as indicated in the What's Important and Meaningful to Me section of the ISP;

vi) The action plan describes the details to meet the participant's goals, preferences, outcomes, health care needs, risk and safety needs and other significant interests;

vii) the action plan identifies the providers, services (waiver and other services) and supports needed to meet the participant's goals, outcomes, and personal preferences. This also includes unpaid supports provided voluntarily;

viii) the action plan also identifies the participant's risk and safety concerns to include the necessary supports to minimize risks and safety concerns;

viiii) the action plan shall include what services are delivered through the consumer directed services option; and

x) the DOH/DDD case manager will complete an action plan revision for any changes that may occur during the 12-month period of the ISP. The waiver agency, DOH/DDD case manager, participant and/or guardian (if applicable) will sign the revised action plan for each change.

The frequency, duration, and timelines for services are specified in the action plan and agreed upon by the participant, guardian (if applicable) and his/her circle of support.

e) During the ISP there is a discussion and decision on how waiver and other services are coordinated and this is recorded in the ISP action plan. These discussions during the ISP meeting may be facilitated by the participant/guardian (if applicable) and the DOH/DDD case manager and within the ISP action plan the person responsible for the services and implementation will be identified. For waiver services the participant/guardian (if applicable) selects a provider from the Medicaid Waiver Providers in Hawaii booklet. The participant/guardian (if applicable) is also informed of the consumer directed services option where they are able to self-direct their own services. Participants/guardians (if applicable) have the option to receive some of their waiver services from Medicaid waiver providers and at the same time self-direct their services through the consumer directed services option. As needed, the participant's QI health plan and DHS are included to facilitate any medically necessary coordination.

i) Waiver services shall not supplant or duplicate services provided by another state agency to include but not limited to the Department of Education, Division of Vocational Rehabilitation, Child and Adolescent Mental Health Division, EPSDT services through the DHS health plans, Adult Mental Health Division, and other private agencies;

ii) services are coordinated by the DOH/DDD case manager's review of the plans from the agencies listed above

with the participant and/or guardian (if applicable). The DOH/DDD case manager shall also arrange for, gather the necessary documents and assist the participant with the application process for services through other agencies as identified by the participant and/or guardian (if applicable). Coordination of services will also include discussions facilitated by the DOH/DDD case managers with the state health plans, community agencies and other agencies as identified through the ISP process with the participant and/or guardian (if applicable); and

iii) the DOH/DDD case manager provides the participant with the option to facilitate their ISP meeting and coordinate the services/supports and is available to help the participant/ guardian (if applicable) who requests any assistance with the facilitation and coordination of their ISP.

f) During the ISP meeting, assigned responsibilities are documented to include the frequency of services/supports as agreed upon by the participant/ guardian (if applicable), DOH/DDD case manager, and circle of support following the review of the participant's needs, preferences, assessments, reports by clinical professionals, waiver provider recommendations and other reports;

i) the ISP action plan section identifies the participant's services/support, frequency and duration, start date, the name of the agency, phone number, and the signature of the representative providing the supports. The participant/ guardian (if applicable) or personal representative also signs the action plan page along with the DOH/DDD case manager;

ii) monitoring of the implementation of the ISP is the responsibility of the DOH/DDD case manager with consultation from the participant/ guardian (if applicable);

iii) following the Hawaii Administrative Rules (HAR) chapter 1738 governing targeted case management DOH/DDD case managers conduct at least quarterly face-to-face contacts and periodic telephone contacts with the participant and /or guardian (if applicable), other agencies and the circle of support to assess/re-assess the participant's goals, outcomes, any health concerns, preferences and recommendations;

iv) during the quarterly face-to-face contact, the case managers shall complete a written quarterly/monitoring review form identifying the progress/status of the participant's goals, needs, desired outcomes, preferences, service delivery, health and safety concerns, and requested updates;

v) DOH/DDD case managers will provide appropriate action and follow up by revising the ISP action plan as changes occur (e.g. unnecessary or inappropriate services/supports or the need for additional services/supports) following a discussion with the participant/ guardian (if applicable);

vi) the DOH/DDD case managers shall also review the action plan page with the participant/ guardian (if applicable) to ensure services and supports are delivered and implemented by the identified service providers (i.e.. paid and unpaid) in alignment with the ISP;

vii) the participant/ guardian (if applicable) signs the Action Plan(s) and Consent for Services forms to verify agreements made during the planning process. The consent form includes information about the steps a participant/guardian can take when disagreements occur. Should the participant and legal guardian (if applicable) elect not to sign or consent to the ISP, the DOH/DDD case manager shall include supporting documentation within the participant's contact log describing the efforts to resolve any discrepancies. A Notice of Action suspending waiver services will be issued to the participant and legal guardian (if applicable) that include appeal rights; and

viii) a copy of the ISP is also given to the circle of support members to verify agreements/assignments and conditions of what needs to happen, as needed.

g) ISPs are completed within 12 months and may be updated at any time as requested by the participant/ guardian (if applicable) and when a participant's needs/goals change or if there are changes in the service/support delivery;

h) all participants shall be present at their ISP meetings unless they choose not to be there. The DOH/DDD case manager shall document within the ISP whether or not the participant is present at their meeting; and

i) participants shall have the opportunity to conduct and facilitate their ISP meeting and may request assistance from their DOH/DDD case manager with this process. The DOH/DDD case manager shall document within the ISP whether or not the participant facilitated their meeting.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

**e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

i) Chapter 333F, HRS, and HAR Title 17 Chapter 1738 identify the critical case management functions of assessment, planning, and ongoing monitoring and service coordination;

ii) DOH/DDD case managers review the participant's assessments (verbal reports from circle members, direct observation of the participant by the DOH/DDD case manager and circle of support (including direct workers), written reports by clinical and other professionals, Inventory for Client and Agency Planning (ICAP) information that identify needed supports and services to minimize existing or potential risk factors;

iii) Information in the ISP is reviewed every 12 months and as the participant's needs or preferences change. Any potential or existing risk factors or conditions are addressed in the participant's Action Plan.

iv) other assessments such as the service planning assessment, e.g. ICAP, may also identify behavior issues and concerns;

v) the quarterly reports from providers and Adverse Event Reports (AER) may also identify other issues which may need to be addressed in the ISP;

vi) the "My Information" section of the ISP identifies contingency plans/back up supports for participants in the event of a natural disaster, emergency or behavioral crisis. The following information is also listed in this section to assist support workers and waiver providers in assisting the participant: health information identifying conditions and contact persons, physician contact numbers, dates of prescribed medications/dosages and the purpose of each medication, list of allergies, special diets, use of any adaptive or specialized equipment, financial, guardian (if applicable) or family/friends contacts and medical insurance plan information;

vii) the DOH/DDD Clinical Interdisciplinary Team (CIT) is the forum for discussion of issues representing medical and/or behavioral challenges/dilemmas. Recommendations of follow up activities from the CIT are provided to the DOH/DDD case managers who then share the information with the participant/ guardian (if applicable), waiver provider, families as applicable, for consideration in the action plan that is sensitive to the participant's preferences;

viii) ISPs include "contingency plans" developed to ensure identification of persons of agencies responsible for various actions and activities; as part of person-centered planning, the roles and responsibilities of the circle of support members may include the identification of a natural support, e.g., family member or neighbor, willing to provide back-up supports. Particularly for individuals with challenging behaviors, a crisis contingency plan is developed to ensure that there is clear communication of what needs to happen during a crisis; and

ix) the provider agreements include the requirement that the waiver provider agency shall have a plan identifying risk and safety factors, e.g. available reliever or back-up staff when the assigned primary direct service worker is unavailable. Further, when necessary, a second provider agency (which is also authorized to render the service required by the service plan) may be identified as "back-up" provider agency at the service plan meetings at which time the details of contacts and other arrangements are clarified. This second agency would be used when the primary agency, as a result of unforeseen circumstances, may be unable to serve the participant. Copies of the ISP are provided to each agency.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

**f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

i) Upon admission to the waiver, participants receive information regarding the availability of qualified providers of each service in each geographic location statewide. As described in Appendix D-1 c (a) participants are informed of services available through the waiver in a variety of ways;

ii) participants are supported in selecting providers. The DOH/DDD case manager reviews the HCBS brochure with each participant. The HCBS brochure lists the waiver services, eligibility criteria, and the process and timeline for admission into the waiver program. Each participant receives a copy of this brochure. Participants may also use the Medicaid Waiver Providers in Hawaii booklet, which lists the waiver services and the agencies that provide each service. It also includes a list of questions so participants or potential participants are free to select service providers. Waiver services and providers are also listed on the DOH/DDD website;

iii) DOH/DDD case managers encourage participants to call and visit agencies to discuss specific questions and comments with agency representatives; and

iv) participants/guardians (if applicable) may choose one or more service providers for one or more services. The choice of providers is discussed during the ISP meeting. Participant's choice of providers is documented in the ISP Action Plan.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

**g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

i) DOH/DDD conducts monitoring on an annual basis utilizing the CMS sampling guide; and

ii) on an annual basis, DHS/MQD will validate a sample of ISPs by reviewing 10% of the non-compliant ISPs reviewed by DOH/DDD. Should discrepancies be identified, a plan of correction is implemented by DHS/MQD to DOH/DDD for remediation.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

**h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ◉ **Other schedule**

*Specify the other schedule:*

Service plans are reviewed no less than annually or when significant changes occur which require service plan updates or upon request of the participant or guardian (if applicable).

**i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

*Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

**a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a) DOH/DDD case managers shall monitor the implementation of the individualized service plan (ISP) and the participant's health and welfare;

b) DOH/DDD case managers at minimum perform quarterly face-to-face visits with the participant and make contact with caregivers, parents, guardians (if applicable), providers, teachers, and employers (as appropriate) and other persons and entities involved with the participant;

i) DOH/DDD case managers assess/review the participant's satisfaction with current services, health status, opportunities for choice, any new health and safety issue and how it will be addressed, and any needed follow-up. Case managers are required, by HAR Title 17 chapter 1738, to do "periodic observations of service delivery to ensure that quality service is being provided" as well as "evaluate whether a particular service is effectively meeting the needs of the recipient";
ii) DOH/DDD case managers obtain information from the participant and service provider (waiver or other service provider). For waiver services, quarterly reports are provided by the home and community based services (HCBS) providers. The DOH/DDD case managers are able to review whether the services are being provided in accordance with the action plan, the participant's progress and determine if the goals and outcomes are being met. This information is also used for discussion and potential ISP updates. The DOH/DDD case manager monitors participant's access to waiver and non-waiver services, effectiveness of back up plans, including health services in the quarterly review form. Within the Action Plan, the participant is free to choose their provider or the self-directed option;
iii) as problems are identified in the quarterly review form, the DOH/DDD case manager will provide follow-up activities with the participant/ guardian (if applicable);
iv) DOH/DDD case managers document any unmet needs and gaps in services based on the assessments, development of the ISP, monitoring of services and completion of the quarterly review form, which is reported to the DOH/DDD administration;
v) Adverse Event Reports sent to the case managers are reviewed for critical event, actions taken (or not taken), and any corrective action plans made. Upon notification of an adverse event that may pose jeopardy to health and welfare, the DOH/DDD case manager will immediately follow up to ensure the participant's health and welfare. In situations where there is an informal report or question concerning appropriate action(s) to be taken, DOH/DDD case managers will follow up with the person(s) or agency(ies) as necessary;
vi) completed Adverse Events Reports are sent to the DOH/DDD staff who review the actions and plans of corrections. DOH/DDD staff may also do follow up reviews with case managers and providers (residential and/or waiver). DOH/DDD staff also work with DHS staff (including Adult Protective Services (APS) and Child Welfare Services (CWS)) to address issues of abuse and neglect. Joint visits with the DOH/DDD case manager and APS or CWS may be completed to review and address a situation with the waiver provider;
vii) DOH/DDD case managers and other DOH/DDD staff may conduct follow up visits or telephone calls in response to issues identified by a participant, legal guardian (if applicable), interested party, or provider, at any time. DOH/DDD case managers, DOH/DDD staff, and DHS staff may also respond to and follow-up on issues of concern identified from Adverse Event Reports. Examples of these may include: providing participant related information to DOH/DDD case managers for their follow up, requiring corrective action plans from providers or DOH/DDD staff and ensuring corrective action plans have been implemented;
viii) monitoring of service plans is done at three levels:
1) at the individual level, by the DOH/DDD case manager;
2) at the program level, by the DOH/DDD internal monitoring quality team (non-case managers); and
3) at the oversight and system level, by DHS; and
ix) DOH/DDD shall also monitor a representative sample of the ISPs on an annual basis (refer to performance measures). DHS will oversee the DOH/DDD monitoring and review non-compliant records. Programmatic and systemic reviews are completed by DOH/DDD and DHS/MQD to identify areas of concern. Systemic

changes/improvements may include revisions of operational policies and procedures, modification of forms or training procedures and identification of new training topics, among others.

Quality assurance monitoring of case management services is conducted annually by the DOH/DDD/OCB staff. Retrospective record reviews of randomly selected participants are conducted to ensure compliance with waiver requirements and ISP policies. When remediation is required by the case management unit, a report of findings is provided to the supervisor identifying service plan implementation or health and safety issues that need to be addressed. The supervisor is responsible for addressing all areas of concern within a specified timeline. Aggregate data from the case management monitoring reviews is collected and reported to DHS/MQD on a quarterly basis. This data is used at the program level for system improvement.

**b. Monitoring Safeguards.** *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Service Plan Assurance/Sub-assurances**

***The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.***

**i. Sub-Assurances:**

**a.** ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% of waiver participants whose individualized service plans (ISPs) include services & supports that align with their needs as indicated in assessments (exclude health & safety risk factors). N: # of waiver participants whose ISPs include services & supports that align with their needs as indicated in assessments (exclude health & safety risk factors) D: Total # of waiver participants sampled**

**Data Source** (Select one):
**Other**

If 'Other' is selected, specify:

**QA/QI Review for Case Management Services**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**#/% of waiver participants whose ISPs include services and supports that align with their needs as indicated in their assessments and validated by DHS/MQD N: # of records validated by DHS/MQD D: Total # of records reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record review**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☑ **Other** Specify: Validation record review |
| | ☑ **Other** Specify: Semi-annually | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Semi-annually |

**Performance Measure:**
**#/% of waiver participants whose ISPs include supports to ameliorate assessed risk factors. N: # of waiver participants whose ISPs include supports to ameliorate assessed risk factors D: Total # of waiver participants sampled whose ISPs identified risk factors**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**QA/QI Review for Case Management Services**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#/% of waiver participants whose ISPs include supports to ameliorate assessed risk factors and validated by DHS/MQD N: # of records validated by DHS/MQD D: Total # of records reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record review**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☑ **Other**<br>Specify:<br>Validation record review |
| | ☑ **Other** | |

| | | |
|---|---|---|
| | Specify:<br>Semi-annually | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Semi-annually |

**Performance Measure:**
**#/% of waiver participants whose ISPs support the participants' personal goals.**
**N: # of waiver participants whose ISPs support the participants' personal goals**
**D: Total # of waiver participants sampled**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**QA/QI Review for Case Management Services**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#/% of waiver participants whose ISPs support the participants' personal goals and validated by DHS/MQD N: # of records validated by DHS/MQD D: Total # of records reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record review**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |

| | | |
|---|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☑ **Other**<br>Specify: Validation record review |
| | ☑ **Other**<br>Specify: Semi-annually | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify: Semi-annually |

**b.** ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% of participants who are present at their person-centered planning meeting to develop the Individualized Service Plan (ISP) N: # of participants who are present at their person-centered planning meeting D: Total # of participant records reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**QA/QI Review for Case Management Services**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | |

**c.** ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% of waiver participants with an ISP updated within 365 days of previous ISP.**
**N: # of waiver participants with an ISP updated within 365 days of previous ISP**
**D: Total # of waiver participants sampled**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**QA/QI Review for Case Management Services**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other** | |

| | | |
|---|---|---|
| | Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#/% of waiver participants with an ISP updated within 365 days of previous ISP and validated by DHS/MQD N: # of records validated by DHS/MQD D: Total # of records reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record review**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | ☐ **Continuously and Ongoing** | ☑ **Other** Specify: Validation record review |
| | ☑ **Other** Specify: Semi-annually | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other** Specify: Semi-annually |

**Performance Measure:**
**#/% of waiver participants who had a change in their needs/condition requiring and resulting in an ISP update. N: # of waiver participants who had a change in their needs/condition requiring and resulting in an ISP update D: Total # of waiver participants sampled who had a change in their needs/condition requiring an ISP update**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**QA/QI Review for Case Management Services**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** |

| | | |
|---|---|---|
| | | Confidence Interval = 95% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**
**#/% of waiver participants who had a change in their needs/condition requiring and resulting in an ISP update and validated by DHS/MQD N: # of records validated by DHS/MQD D: Total # of records reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record review**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| | | |

| | | |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☑ **Other** Specify: Validation record review |
| | ☑ **Other** Specify: Semi-annually | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other** Specify: Semi-annually |

**d.** ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% of waiver participants whose services (type, amount, frequency, duration) were provided as specified in their ISPs. N: # of participant records where the services (type, amount, frequency, duration) were provided as specified in their ISPs. D: Total # of participant records in the sample**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**QA/QI Review of Hawaii's I/DD Waiver Providers**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% of waiver participants with documentation of choice offered among waiver services for which there has been an assessed need by the case manager. N: # of waiver participants with documentation of choice offered among waiver services for which there has been an assessed need by the case manager D: Total # of waiver participants sampled**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**QA/QI Review for Case Management Services**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| | | |

| | | |
|---|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#/% of waiver participants with documentation of choice offered among waiver services for which there has been an assessed need by the case manager and validated by DHS/MQD N: # of records validated by DHS/MQD D: Total # of reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record review**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| | | |

| | | |
|---|---|---|
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☑ **Other** Specify: Validation record review |
| | ☑ **Other** Specify: Semi-annually | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other** Specify: Semi-annually |

**Performance Measure:**
**#/% of waiver participants with documentation of choice offered among available providers. N: # of waiver participants with documentation of choice offered among available providers D: Total # of waiver participants sampled**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**QA/QI Review for Case Management Services**

| **Responsible Party for data** | | **Sampling Approach** *(check each that applies):* |
|---|---|---|

| **collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**Performance Measure:**

**#/% of waiver participants with documentation of choice offered among available providers and validated by DHS/MQD N: # of records validated by DHS/MQD D: Total # of records reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record review**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☑ **Other** Specify: Validation record review |
| | ☑ **Other** Specify: Semi-annually | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other** Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | ☑ **Other**<br>Specify:<br>Semi-annually |

**Performance Measure:**
**#/% of waiver participants with documentation of choice offered to self direct if applicable. N: # of waiver participants with documentation of choice offered to self direct if applicable D: Total # of waiver participants sampled receiving services for which self direction is an option**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**QA/QI Review for Case Management Services**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#/% of waiver participants with documentation of choice offered to self direct if applicable and validated by DHS/MQD N: # of records validated by DHS/MQD D: Total # of records reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record review**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☑ **Other**<br>Specify: Validation record review |
| | ☑ **Other**<br>Specify: | |

| | | |
|---|---|---|
| | Semi-annually | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Semi-annually |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Scheduled record reviews and satisfaction surveys performed by DOH/DDD assist in identifying individual as well as systemic problems. If a record is found to be out of compliance, e.g. ISP was not updated, DOH/DDD is responsible to ensure that the ISP is updated and to track and document this when completed. DOH/DDD submits the record review and survey results to DHS/MQD. DHS/MQD performs its own review of records reviewed by DOH/DDD that were determined to be out of compliance.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| | ☑ **Other**<br>Specify:<br><br>Semi-annually |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix E: Participant Direction of Services

**Applicability** *(from Application Section 3, Components of the Waiver Request)*:

- ◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** *(select one):*

- ○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

### E-1: Overview (1 of 13)

**a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

a) Under the Consumer Directed Service option, participants and/or their designated representatives exercise Employer Authority to hire, train, supervise, and when necessary, discharge their direct support workers. Participants who elect to self-direct their services also have Budget Authority to manage how their budget is spent. The Consumer Directed Service option is available for the following services: Chore, Personal Assistance/Habilitation, Community Learning Services, Respite, and Non-Medical Transportation. Participants may direct one or more of these 5 services. Participants may designate the support of a representative including a legal representative (for example, a guardian) or a non-legal representative. The designated representative is chosen specifically to support the participant in exercising Employer and Budget Authority.

b) During the Individualized Service Plan (ISP) development process, the case manager informs the participant of the Consumer Directed Service option. If the participant expresses interest, he or she participates in an orientation to learn more about the benefits, responsibilities and liabilities of this option. If the participant elects to self-direct

services, a meeting is held with the participant, designated representative and case manager to further develop the ISP and determine how the participant will exercise Employer Authority, including what supports are needed.

The Consumer directed budget allocation is determined as part of the person centered planning process and is based upon an assessment of needs and costing out of chosen services based on established rates. Participants may adjust the utilization of their consumer directed services without prior approval if the services are used as specified in the ISP and within their individual budget allocation.

c) Many individuals and entities support participants who use the CD Services option. The DOH/DDD Case Manager provides initial information and assistance regarding the consumer directed service option. The DOH/DDD Consumer Directed Specialist is also available to provide additional information for the participant. The Financial Management Service (FMS) entity provides fiscal services related to federal and state taxes, social security tax withholding and any other required insurance coverage. In addition, the FMS provides monthly reports on payroll expenditures and remaining budget balances to that the participant can monitor his/her budget. Expenditure reports are also made available to the Case Manager for monitoring the delivery of services and the health and safety of the participant. The FMS assists participants in verifying workers' citizenship, collects and processes timesheets of workers and conducts the Criminal Record History Check of employees.

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

**b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☑ **The participant direction opportunities are available to persons in the following other living arrangements**

  Specify these living arrangements:

  Participant directed opportunities are limited to individuals living in certified Adult Foster Homes (2 persons), Developmental Disabilities Domiciliary Homes (5 persons), Adult Residential Care Homes (5 persons) and Expanded Adult Residential Care Homes (6 persons).

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**

◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a) A variety of written materials about the Consumer Directed option are available to all waiver participants. These include the Consumer Directed Brochure, the HCBS brochure and the Developmental Disabilities Council Guide for participants receiving HCBS.

During the ISP development process, the case manager shares the CD Option and provides the participant and his or her representative (if applicable), the Consumer Directed Brochure.

Once the participant decides to participate in the Consumer Directed Services option, more information is provided in the CD orientation. Each participant and the designated representative (if applicable) receives a consumer directed services handbook that is used and reviewed in the orientation. The orientation includes the benefits and responsibilities of the Consumer Directed Services option, employer and employee responsibilities. The FMS will provide training on recruitment, hiring, supervision, training and discharge of employees, responsibility for submission of timesheets, budget management and the tax and legal employer forms and responsibilities.

b) DOH/DDD Case Manager, DOH/DDD Consumer Directed Specialist, FMS are responsible for furnishing the necessary information to the participant and/or designated representative.

c) Information is presented at the initial service planning meeting and at least annually or upon request. As stated, this option is included in the HCBS brochure which is also distributed upon admission into the waiver and as applicable. A waiver participant can request information on the Consumer Directed Services option at any time.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

**f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

○ **The State does not provide for the direction of waiver services by a representative.**

◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☑ **Waiver services may be directed by a legal representative of the participant.**

☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

During the person-centered planning process, the choice of consumer directed services may be made. The participant, their guardian or non-legal representative may initial the acknowledgement in the ISP action plan attesting that the participant has a choice of selecting the consumer directed services option.

Whenever possible, the participant is provided supports to direct consumer-directed (CD) services as the employer. The employer must be at least 18 years of age. The employer will have employer authority to recruit, hire, schedule, train, supervise and terminate employees. In addition, the employer will have budget authority to make decisions over a CD budget and responsibility to manage the allocation of dollars. If the participant is unable to carry out the duties of an employer, a designated representative can be appointed to serve as the employer. The adult participant may freely choose a non-legal representative to serve as the employer. If the adult participant has a legal guardian of the person, the guardian may assist the participant to choose a non-legal representative to serve as the employer. The circle members will ensure that the non-legal representative chosen by an adult participant is someone who supports choices and decisions by the participant and who will not directly (or indirectly) benefit financially. Ideally, the non-legal representative is one who has a personal interest and relationship with the adult participant.

In order to minimize potential conflict of interest and to provide safeguards for the participant, the DOH/DDD has implemented a policy that the legal representative assisting the participant to choose a designated representative as the employer and the designated representative cannot be paid for providing waiver services. As situations arise, DOH/DDD provides technical assistance and supports to address how and what supports may be provided to ensure that the participant receives quality services in a manner desired by the individual and in the individual's best interests.

The Consumer Directed Specialist assists case managers and individual participants and/or designated representatives regarding procedures for enrollment and payment. The DOH/DDD monitors consumer-directed providers as part of its quality monitoring. DHS/MQD oversees DOH/DDD's monitoring of consumer-directed providers.

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

| Waiver Service | Employer Authority | Budget Authority |
|---|---|---|
| Community Learning Services (CLS) | ☑ | ☑ |
| Chore | ☑ | ☑ |
| Personal Assistance/Habilitation (PAB) | ☑ | ☑ |
| Respite | ☑ | ☑ |
| Non-Medical Transportation | ☑ | ☑ |

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

**h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

- [ ] **Governmental entities**
- [x] **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

**i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

**The waiver service entitled:**

◉ **FMS are provided as an administrative activity.**

**Provide the following information**

**i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Under the Employer Authority, the FMS will be required to support the participant to meet all state and federal statutory requirements through payroll processing. The FMS is selected through an administrative selection process.

**ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

The agent is paid a monthly service fee per participants.

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

*Specify:*

Process Criminal History Record Check. Ensure support workers meet qualifications specified by participants. Provide orientation and skills training for participants or their designated representatives related to common law employer functions

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

*Specify:*

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☐ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☑ **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- ☑ **Other**

*Specify:*

Make individual expenditure reports available to DOH/DDD Case Manager.. Provide consolidated expenditure reports to designated DDD administrative staff. Provide an orientation packet and manual to each participant that is provided FMS. The packet includes all employer required forms and training materials.

**iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The DOH/DDD is responsible under its competitive procurement and contracting procedures to monitor and assess the performance of the FMS entity. Based upon contractual specifications, the FMS must provide remediation for any items not meeting expected requirements. The FMS must provide monthly expenditure reports to the individual and the DOH/DDD. Expenditures must be reconciled against an approved individual budget and result in timely notice to the individual and DOH/DDD Case Manager of specified variances in expenditures. Quarterly reports by the FMS will track expenditure trends and be sent to the DOH/DDD. The FMS is required to keep a log of complaints.

Quarterly meetings will be held with the FMS entity and DOD/DDD. Phone contact will be used for any issues that arise between regularly scheduled meetings.

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

During the participant-centered planning process, case managers explain services and service options including consumer directed services as defined in E-1-e. The DOH/DDD Consumer-Directed Specialist and case manager provide ongoing information and assistance.

The participant may use consumer directed personal assistance exclusively or in conjunction with agency managed services. They may change their selection at any time.

The case managers monitor the delivery of consumer-directed services on a quarterly basis.

☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

| Participant-Directed Waiver Service | Information and Assistance Provided through this Waiver Service Coverage |
|---|---|
| Skilled Nursing | ☐ |
| Community Learning Services (CLS) | ☐ |
| Training and Consultation | ☐ |
| Individual Employment Supports | ☐ |
| Private Duty Nursing (PDN) | ☐ |
| Vehicular Modifications | ☐ |
| Chore | ☐ |
| Specialized Medical Equipment and Supplies | ☐ |
| Personal Assistance/Habilitation (PAB) | ☐ |
| Adult Day Health (ADH) | ☐ |
| Additional Residential Supports | ☐ |
| Personal Emergency Response System (PERS) | ☐ |
| Respite | ☐ |
| Discovery & Career Planning (DCP) | ☐ |
| Non-Medical Transportation | ☐ |
| Residential Habilitation (ResHab) | ☐ |
| Environmental Accessibility Adaptations | ☐ |
| Waiver Emergency Services | ☐ |
| Assistive Technology | ☐ |

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

**k. Independent Advocacy** *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

**l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The case manager works with participants during the person centered planning process to identify the type and amount of supports needed. Participants may use consumer directed personal assistance exclusively or in conjunction with agency managed services. They may change their delivery method at any time; in general, back-up plans are required for participants using the consumer directed option, including identifying back-up natural supports, consumer directed workers and agency provider(s). When participants voluntarily terminate the consumer directed option, the case manager re-assesses the needs of the participant and authorizes the appropriate number of agency hours.

The case manager will assure the health and welfare of the participant; no services are terminated until needed substitute services, either by an agency or natural supports, are being provided.

Natural supports will not supersede the transition to provider supports.

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

**m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Circumstances:
a) when participant's preferred direct support worker is unable or unwilling to provide the service and there are no options desired by the participant;
b) when participant's preferred direct support worker has been confirmed as a perpetrator of abuse (including financial) and/or neglect of the participant;
c) when the participant's preferred direct support worker(s) do not or cannot provide appropriate services, potentially endangering the participant's health and welfare;
d) when there is no back-up available; and
e) when the participant or his designated representative continually fails to meets consumer directed program requirements, e.g., continual inability to manage the budget, untimely submittal of employee timesheets and vouchers, submittal of incorrect vouchers, failure to deliver payment to workers, failure to maintain service records, inability to hire, train, supervise or retain workers, authorization of services that are not in accordance with ISP, inadequate protection of health and welfare, commission of fraudulent or criminal activity associated with self-direction etc.

For participants who utilize the consumer directed option, the case manager generally is the first line of quality assurance, providing regular ongoing monitoring. Prior to starting consumer directed services, the participant and/or his designated representative shall have a back-up plan in place. Back-up plans include natural supports, other consumer directed workers and/or a provider agency to assure ongoing supports – it is preferable to have at least two natural supports and/or consumer directed workers and a provider agency, as a final back-up to provide services. In situations where the participant's health and welfare may be in jeopardy, the case manager may immediately effect the implementation of the back-up plan after discussion with the participant and/or designated representative; the case manager may take other appropriate action if necessary (including referral for protective services assistance.) The case manager will, during the transition, facilitate access, coordinate, monitor and assess the need for supports, e.g., other waiver services or other types of services.

The case manager will assure the health and welfare of the participant, arranging for agency provided services or natural supports as soon as the case manager is aware of the need.

Natural supports will not supersede the transition to provider supports.

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

**n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

**Table E-1-n**

| | Employer Authority Only | Budget Authority Only or Budget Authority in Combination with Employer Authority |
|---|---|---|
| **Waiver Year** | **Number of Participants** | **Number of Participants** |
| **Year 1** | | 675 |
| **Year 2** | | 700 |
| **Year 3** | | 725 |
| **Year 4** | | 750 |
| **Year 5** | | 775 |

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant Direction (1 of 6)

**a. Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

**i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

**ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

- [ ] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [x] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Criminal history record checks are obtained by the FMS entity and the cost incorporated into the monthly fee.

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (2 of 6)

**b. Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [x] **Other**

Specify:

Funds for the CD services in the ISP and reflected in the budget may be reallocated among CD services subject to the intent of the CD services in the ISP and within the allocated budget. Goods are not procured under the CD option.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (3 of 6)

**b. Participant - Budget Authority**

**ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The budget for CD services is based upon an assessment of needs that can be met with CD services. This will result in the identification of the specific units for each CD service (Chore, Respite, Personal Assistance/Habilitation, Transportation or Community Learning Service) to be used on an annual basis. The CD services are costed out based on the existing rates for each CD service. The sum of the cost of projected CD services needed by the participant is considered the annual CD budget for the person. This budget is considered the upper limit of the funds controlled by the participant.

Once the amount of the annual budget is identified and documented on the person's Individualized Service Plan, the participant has the authority to :(1) change the type CD services to be utilized, (2) revise the amount and frequency of CD services to be utilized, (3) set the hourly wage of employees (within a range of wages for comparable work in the geographic area) and authorize overtime. This authority is subject to the limit of the annual budget. Monthly expenditure reports will be submitted by the FMS to the participant and the case manager for monitoring. If a change in the participant's condition reflects a need for an increase of CD services, the DOH/DDD Case Manager must be notified and any budget increase approved by the DDD.

The budget methodology will be included in the Consumer-Directed Employers Manual which will be posted on the Developmental Disabilities Division (DDD) website. The Consumer-Directed Employers Manual is seen to be the single source of information for employers as well as for prospective employers seeking information on consumer-directed services. The budget methodology will be posted on the DDD website.

The Individual Supports Budget will be implemented over a three-year phase-in starting July 1, 2018. Until CD participants have an Individual Support Budget, their CD budgets will be based on the process described above. The base service mix for the Individual Supports Budget includes most of the services that can be consumer-directed (Personal Assistance/Habilitation, Community Learning Services, Respite, and Chore). Non-Medical Transportation is funded in addition to the Individual Supports Budget as an "add-on" service. When the participant receives their Individual Support Budget, that budget represents the total cost of their waiver services authorized in the Individualized Services Plan (ISP). The participant can choose to direct a portion or all services that can be consumer-directed within the Individual Supports Budget. The participant may decide on a combination of CD and agency-provided services, depending on his or her needs and preferences. The participant will determine the amount of dollars to be allocated to CD services from the Individual Supports Budget and add-on services that can be consumer-directed. The amount of dollars for each CD service will be documented in the Action Plan section of the ISP with the frequency, duration and timelines for each CD service. The total dollars allocated for the CD portion of the Individual Supports Budget and the "add-on" Non-Medical Transportation will constitute the CD budget.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

**b. Participant - Budget Authority**

**iii. Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The budget development is part of the person-centered planning process which includes an individualized needs assessment and the services to meet those needs. The individual's ISP team members are process along with the DOH/DDD Case Manager to develop the budget. Final approval of the budget allocation is reviewed by the DOH/DDD Branch and communicated to the participant by the DOH/DDD Case Manager.

Any requests for an increase in the budget are reviewed by the DOH/DDD Utilization Review Committee. The Committee will review the reason for the request and consider related factors in accordance with DOH/DDD policy for review of requests. The Committee's decision may be appealed to the DOH/DDD and/or to the State Medicaid Agency.

If the State denies requested services in whole or in part due to the limits established by Individual Supports Budgets, the participant will be informed of their right to appeal and request a fair hearing, consistent with the requirements of 42 CFR 431.200 et seq.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

**b. Participant - Budget Authority**

**iv. Participant Exercise of Budget Flexibility.** *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Adjustments may be made among CD services listed in the ISP without approval if it is within the allocated budget and consistent with the intent of the service identified in the ISP. Any reduction of a CD service addressing a health and safety issue should be discussed with the DOH/DDD Case Manager before the adjustment is made.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

**b. Participant - Budget Authority**

**v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FMS operates a web-based information system to track individual monthly payroll expenditures. The participant and DOH/DDD Case Manager will receive monthly reports in which any variance of 10% between monthly expenditures and the planned budget will be highlighted. The Case Manager will follow up with the participant for unresolved budget problems. Quarterly reports will be compiled by the DOH/DDD to systemically monitor expenditures and CD service utilization trends for Quality Improvement actions. The quarterly reports will be submitted to the state Medicaid Agency for oversight review.

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The individual (or his/her legal representative) is informed of the opportunity to request a fair hearing at various points in the process of admission and service delivery. For purposes of this section, the term "individual" means a person who is applying for, but not yet determined eligible for, the waiver and includes his/her legal representative. The term "participant" means a person who is eligible for and enrolled in the waiver and includes his/her legal representative.

As part of the waiver application and enrollment process, individuals are provided information about waiver home and community-based services (HCBS) at the first meeting with the DOH/DDD case manager. At the initial meeting, the DOH/DDD case manager explains the difference between institutional services and waiver HCBS, the HCBS waiver program and HCBS requirements (Medicaid eligible, meet Intermediate Care Facility for Individuals with Intellectual Disabilities [ICF/IID] level of care, information requirements, etc.), and gives the individual a choice between institutional services or HCBS. Formal written notice and information about how to request an administrative hearing are provided to any individual determined to be ineligible for the waiver.

Once enrolled in the waiver, participants, the DOH/DDD case manager provides the DOH/DDD HCBS and Appeals brochures. These brochures provide information on the process for appealing any adverse action taken by the DOH/DDD on waiver services. Participants are provided the option of requesting an informal process with DOH/DDD prior to the formal administrative hearing at DOH/DDD or DHS/MQD. DHS/MQD and DOH/DDD Information about Grievance and Appeals is provided at least annually at the person-centered planning meeting by the DOH/DDD case manager.

During the course of reevaluating the participant's level of care, needs and services, the DOH/DDD case manager informs participants of their right to appeal where there is any adverse action, (i.e., when waiver services are suspended, reduced or terminated). Participants are informed of the right to be notified in advance of the adverse action being taken, the right to request an informal review by DOH/DDD, and the right to request an administrative hearing before a DOH/DDD Hearing Officer and a DHS/MQD Hearing Officer. Participants are advised of the right to be represented by a representative at the hearing. Participants are informed that current services continue during the pendency of the information review and appeal. Participants are informed of the right to forgo the informal review with DOH/DDD and proceed directly with an administrative hearing with either DOH/DDD or DHS/MQD.

Where waiver services are suspended, reduced or terminated, the DOH/DDD case manager completes a Notice of Action (NOA) form to inform the participant of the adverse action and the reason for the action. The Notice of Action form is provided at least ten (10) working days prior to the action being taken, per Hawaii Administrative Rules (HAR) § 11-88.1-10(b) except in circumstances as defined in HAR §17-1713(1)(c) where adequate notice shall be sent not later than the date of the action. A copy of the Notice of Action form is kept in the participant's case file.

# Appendix F: Participant-Rights

## Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair

Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

# Appendix F: Participant-Rights

## Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The DOH/DDD handles grievance/complaints relating to the DOH/DDD eligibility and waiver services.

Participants are informed that filing a grievance or making a complaint are not pre-requisites or substitutes for a Fair Hearing.

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a) The DOH/DDD has a Consumer Complaints Resolution Unit (CCRU) that is responsible for receiving concerns/complaints/appeals for DDD services. These are issues that have not been resolved at either the case management unit level, provider level, or system level. These issues may include complaints against case managers, about a process or processes that did not occur as perceived by the complainant, about service delivery, and about decisions affecting service delivery. The DOH/DDD is responsible for receiving the complaints/concerns and tracking them to ensure they are handled in a timely manner.

b) Complaints may be registered verbally or in writing by email or letter. Initial response to complaints is provided within 24 hours, or the next working day following receipt. Timeline for resolution of complaints is one month.

c) The CCRU gathers information related to the complaint from the case manager, provider or other party with information about the complaint. The CCRU attempts to resolve the complaint by identifying the action(s), if applicable, that could improve the situation. If the complaint is related to a DOH/DDD employee, if appropriate, the complainant is referred to the Department of Health Personnel policies and procedures regarding labor relations.

Participants are informed that they are able to request a Fair Hearing and that the use of the Grievance process does not replace a Fair Hearing.

# Appendix G: Participant Safeguards

## Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

As indicated in the Division's Adverse Event Report Policy, all waiver providers, DOH/DDD case managers, consumer-directed employers, adult foster home certified caregivers, and individuals involved with the participant, e.g., families, guardians (if applicable) and workers, are required to report occurrences of the following adverse/critical events on the Adverse Event Report (AER) Form:

1) suspected abuse, neglect, or financial exploitation of a participant. Abuse includes physical, psychological, and sexual abuse. An incident in this category must also be reported to Adult Protective Services (APS) or Child Welfare Services (CWS) pursuant to Section 346-222, Hawaii Revised Statutes (HRS) and Section 350-1, HRS;

2) injuries of a known or unknown cause requiring medical or dental treatment rendered by ambulance or emergency medical personnel, urgent care or emergency room medical staff or dentist, or results in hospitalization;

3) medication errors that include wrong medication, wrong dose, wrong time, or missed dose;

4) changes in the participant's behavior, including but not limited to aggression, self-injurious behaviors, property destruction, sexualized behaviors that may require a new or updated Behavior Support Plan as a result of the intensity and/or severity of the behavior;

5) changes in the participant's health condition requiring medical or dental treatment rendered by ambulance or emergency medical personnel, urgent care or emergency room medical staff or dentist, or results in hospitalization;

6) death of a participant;

7) whereabouts unknown regardless of the amount of time a participant was missing or unaccounted for;

8) any use of restraints such as chemical, mechanical, and physical; and

9) any use of seclusion in which the participant is confined to a room/area and prevented from leaving by closing the door or using another barrier.

All adverse events are reported to the DOH/DDD case manager. All Waiver Providers, Consumer-Directed Employers, and Adult Foster Home Certified Caregivers must make a verbal report within 24 hours or next working day of the critical event and submit a written AER form within 72 hours (exclusive of weekends and holidays) to the DOH/DDD case manager. Based on the available information, the DOH/DDD case manager must assess if there is potential for further injury or harm to the participant and/or others in the home or program setting, and notify his/her supervisor immediately. The supervisor in consultation with his/her section supervisor, Case Management Branch Chief, DOH/DDD Administrator, and DOH/DDD Medical Director will determine if an initial onsite assessment is warranted and identify the DOH/DDD staff who will be conducting the assessment.

For incidents involving alleged or suspected abuse, neglect, or exploitation, within 24 hours of receiving the verbal report, the DOH/DDD case manager must gather relevant information (date, time, and location of the event, identify persons involved, identify alleged perpetrator), assess the extent of injury or harm to the participant, verify actions taken to provide for the participant's immediate safety, and confirm if a report was made to APS or CWS. If a report to APS or CWS was not made, the DOH/DDD case manager shall make a report immediately. The DOH/DDD case manager shall notify his/her supervisor of the allegations and conduct a face-to-face interview with the participant to determine if additional medical treatment or actions are necessary to safeguard the participant. If the participant has

a legal guardian and it is believed that the legal guardian is not involved in the incident, the DOH/DDD case manager will inform the guardian of the situation and discuss a recommended plan of action. The DOH/DDD case manager shall work in collaboration with the APS or CWS worker and notify the respective licensing and certifying agency if the participant resides in a licensed or certified home.

As indicated in the Mandatory Reporting of Abuse and Neglect Policy, all DOH/DDD employees are mandated to report and follow-up on any allegations or incidents of suspected abuse, neglect, and/or exploitation of DOH/DDD participants. DOH/DDD employees shall comply with all HIPAA requirements related to the disclosure of protected health information to APS, CWS, and police, as referenced in this policy.

Upon receipt of the written AER form, the DOH/DDD case manager is responsible for:

1) documenting whether reporting timelines were met;
2) determining if the information in the report is accurate and complete and if not, requiring the reporter to re-submit an updated/revised report;
3) assessing the appropriateness of the immediate action taken to safeguard the participant;
4) assessing the appropriateness of the plan of action to prevent the recurrence of the event;
5) ensuring the participant's health and safety by making a face-to-face visit with the participant or phone contact with the reporter to get an update on the participant's current status;
6) assessing if additional actions are warranted to prevent the recurrence of the event;
7) updating the participant's Individualized Service Plan if there are risks factors that need to be addressed and identifying the supports to minimize the assessed risks; and
8) conducting ongoing monitoring of services to assure implementation of any corrective action plans. At a minimum, the DOH/DDD case manager shall consult with the unit RN or RN designee for all adverse events involving medication errors, changes in the participant's health condition requiring medical or dental treatment, and when an adverse event results in hospitalization.

The DOH/DDD case manager is responsible for documenting all actions taken in response to the event on the AER form and submitting the report to his/her supervisor for review and signature. This part of the AER form must be submitted to the Waiver Provider, Consumer-Directed Employer, or Adult Foster Home Certified Caregiver who reported the event within five (5) working days of receiving the written report.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

A DOH/DDD brochure on rights and responsibilities of a person with a developmental disability is available. Included in this brochure is a section on abuse including rights, signs, and actions to be taken. This brochure is shared with case managers for use as part of their discussions with participants and/or their legal guardian (if applicable) or designated representatives. This brochure is also incorporated in training for stakeholders, e.g., individuals (to be shared as part of self-advocacy training), families, case managers, providers, and other interested stakeholders.

Whenever allegations of abuse are made, the DOH/DDD case manager informs the participant and/or legal guardian (if applicable)/designated representative of the allegations, concurrently explaining reportable events according to the CWS and APS laws. The case manager, in further follow up discussions and queries with the participant or the participant's legal/designated representative, will discuss more fully, the participant's rights and the actions or inactions that are considered to be abuse, exploitation, or neglect.

The waiver providers are required to inform the participant and/or the legal guardian (if applicable) or designated representative of participant's rights, including being free from exploitation, neglect, and abuse. Additionally, the participant signs an acknowledgement form annually which reviews these rights.

**d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Program Services Evaluation Unit (PSEU) is responsible for the oversight of the adverse event reporting system, which includes receiving and evaluating all adverse event reports, verifying that corrective action was implemented, and analyzing the information to identify trends/patterns and to make recommendations for quality improvement.

PSEU staff will evaluate each adverse event report to determine whether or not appropriate actions were taken to prevent the recurrence of the event and to assure the participant's immediate safety. Incidents involving suspected abuse, neglect, or exploitation are reported to APS or CWS, as appropriate. The PSEU staff will assure mandatory reporting requirements are met for incidents involving suspected abuse, neglect or exploitation of a participant.

When the AER form includes documentation ensuring the participant's health and welfare and there is a plan in place to prevent the recurrence of the reportable event, the AER is closed and no additional follow-up is required. If additional documentation or follow-up is required by the DOH/DDD case manager (form is incomplete or contains inaccurate information, or critical information is missing), the PSEU staff will notify the respective Case Management Branch staff and request that the additional information be submitted in writing. For events that require follow-up because of the potential to impact the health and welfare of the participant or others in the residential or program setting, the PSEU staff will notify the respective Branch staff overseeing the Adult Foster Home or Waiver Provider Agency and request a plan of action to address the identified issues.

Investigations will be conducted by PSEU staff and others designated by DOH/DDD for the following circumstances: Any death as a result of:

1) serious injury that required treatment in the emergency room or urgent care or resulted in a hospitalization;
2) medication error;
3) elopement;
4) unknown circumstances;
5) the use of restraint or seclusion; and
6) any and all other situations identified by the DOH/DDD Administrator or Outcomes and Compliance Branch Chief as requiring an investigation.

Investigations will be conducted within 72 hours of receiving the written AER form from the DOH/DDD case manager. Depending on the range of activities required to complete each investigation, the timeframe for completing an investigation may take up to 30 days. Within 14 days of completing the investigation, the participant's family or legal guardian, if applicable and other relevant parties will be informed of the investigation results.

All instances of suspected abuse and neglect must be reported to the DHS Adult Protective Services (APS) or Child Protective Services (CPS) intake units. DHS has policies and procedures to address the reports and resolutions. For waiver provider agencies, the Provider Service Agreement stipulates that they must inform the DOH/DDD case manager and DHS (APS or CPS) within 24 hours of the occurrence of a critical event and submit a written report within 72 hours.

For all other types of critical events or incidents as defined in G-1-b, the following process will be followed. When DOH/DDD case managers are notified of critical events, they are required to complete the Adverse Event Report (AER). The DOH/DDD case managers assess the information related to the adverse/critical event(s) that is submitted by the individual or agency, e.g. waiver Provider. DOH/DDD case managers are required to respond to critical incidents within the first working day; coordination with DHS (APS or CPS) is done as necessary to ensure coordinated service planning. DOH/DDD case managers provide follow-up activities by contact, through telephone calls or face-to-face meetings or both, with the participant or the participant's legal or designated representative, to insure that the participant is safe. They obtain additional information required to determine what follow-up actions may be necessary, i.e., alternate placement of participant into another living environment, revising the service plan, arranging for a medical evaluation/follow-up treatment, providing more information to enforcement agencies, coordinating training or other supports, etc. Follow-up actions may include conducting on-site reviews and interviews with the collaterals. This may include a review of the provider in consultation with DHS to determine that corrective actions (for participant and by provider) are adequate. Following completion of interviews and fact finding, case managers inform the participant and/or guardian (if applicable) of the results, including recommended actions to be taken by the case manager, as these often include presenting options for different providers of particular services, e.g., residential, agency, direct support worker, etc. Investigations will be completed as soon as possible but typically within 30 days.

Data relating to critical events are analyzed and statistical reports prepared, e.g., information on trends, patterns, indicators of how services are rendered to each participant, etc. and reviewed by DOH/DDD for identification of issues of concern, i.e., trending analysis, corrective action plans (agency, case manager, supervisors) and follow-up action, e.g., monitoring, training, etc. In addition to responding to individual occurrences of adverse/critical events, emphasis would be on the adequacy of the Providers' ongoing Quality Assurance activities. Areas of deficiencies will be addressed by DOH/DDD and monitored by DHS/MQD.

For adverse/critical events, case managers and agency staff are expected to respond immediately to begin information gathering or the investigative processes. The timelines for reporting are previously addressed in this document. Actions taken by the direct support worker, agency, case manager, and/or APS or CPS are expected to be driven by the nature of the critical event and agency policies and procedures. Of foremost concern is the health and welfare of the participant.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Providers submit adverse/critical events on an Adverse Event Report (AER) form. These are collected, tracked, and reviewed by DOH/DDD using the database mentioned above. DOH/DDD follows guidelines that are issued by DHS/MQD and follows established policies and procedures.

DOH/DDD and DHS/MQD are responsible for overseeing that adverse/critical events, including all incidents of abuse and neglect, are reported and are satisfactorily addressed and resolved. The frequency of quality assurance reviews by DOH/DDD and reports received by DHS/MQD varies depending on the specific type of information gathered. Refer to Quality Improvement sections located at the end of this appendix for specific information and frequencies. An overview of this oversight includes:

1) review of all AERs submitted by DOH/DDD, which will comprise of an aggregation and analysis of 100% of AERs received. DHS/MQD will notify DOH/DDD if further remediation, corrective action, or system improvement is needed;
2) detailed review of AER Reports for all deaths; and
3) detailed review of AER Report for participants or providers that raise concerns based on monitoring trends.

All waiver providers are required to have an Internal Quality Improvement program that includes a process for providing ongoing monitoring, quarterly assessments and trending of Adverse Events for appropriateness of action taken, follow-up and preventive actions to be taken.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical

restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DOH/DDD's Positive Behavioral Support (PBS) P&P 2.01 ensures a PBS approach with all Waiver participants. It establishes practices to allow people to engage in adaptive and socially desirable behaviors for meaningful/productive lives. It also promotes participants' participation in integrated activities. The P&P sets forth core values of supporting people by expanding opportunities and enhancing quality of life.

P&P 2.01 defines specific procedures for the development of behavior support plans (BSP) including that BSPs must be developed for people who engage in behaviors that threaten the health and safety of themselves or others, or that limits the participant from participation in an integrated activity. It requires the BSP be developed per Act 199 of 2015.

The purpose of P&P 2.01 is to limit/specify restrictive procedures to ensure restrictive measures are used only for the protection of participants from imminent harm to self or others; are used after less restrictive interventions have been attempted; participants are supported in caring, responsive environments free from abuse; supports are based on understanding the participant has reasons for their actions; and effort is directed at creating opportunities for participants to exercise choice.

Restrictive procedures are defined as procedures that restrict a participant's freedom of movement, access to property, or require a participant to do something which they do not want to.
Aversive procedures are intended to inflict pain, discomfort and/or social humiliation to modify behavior including electric skin shock, liquid spray to one's face and strong, non-preferred tastes applied in the mouth. These are prohibited.

"Behavior Support Plan" outlines the steps that will be taken by the members of the participant's team to modify the physical environment, teaching of replacement skills, how team members should respond to challenging behaviors, and ways to decrease the likelihood of challenging behaviors from occurring. The BSP is developed based on the results of a Functional Behavior Assessment (FBA).

"Chemical Restraint" means psychotropic medication prescribed by a licensed health care professional with prescriptive authority: on a routine basis without an appropriate Diagnostic and Statistical Manual (DSM) diagnosis for the purpose of behavioral control; or the incidental use of medications, sometimes called PRN or as needed medication, to protect the participant from imminent harm to themselves and/or others through temporary sedation or other related pharmacological action. The P&P also defines actions that are not considered chemical restraints.

"Mechanical Restraints" means a restraint which a device, material or equipment is involuntarily applied to the participant's body or immediate environment that immobilizes, restricts, limits, or reduces any bodily movement. The P&P also defines devices that are not considered mechanical restraints and prohibitions.

"Physical Restraints" means a restraint in which physical force applied to the participant and involuntarily restricts their freedom of movement or normal access to portion or portions of their body. Refer to Policy 2.02 Restrictive Procedures for additional information and DOH/DDD parameters for use of Physical Restraints, including prohibitions and limitations.

"Restraints" means physical, chemical or mechanical interventions used as a last resort on an emergency basis to protect the participant from imminent harm to themselves and/or others using the least restrictive means possible and for the shortest duration necessary.

"Restrictive Procedures" means a procedure that limits a participant's freedom of movement, access to other locations, property, or rights.

"Seclusion" means a restrictive procedure in which a participant is involuntarily confined in a room or area from which they are prevented from having contact with others or leaving by closing a door or using another barrier. This is prohibited.

The Restrictive procedure policy P&P 2.02 states these procedures may only be used for protection from imminent risk of serious harm to self or others, and may not be used in situations where there is no need for protection; only the least restrictive procedures to adequately protect the participant and others from harm shall be used, and restrictive procedures must be terminated as soon as the need for protection is over and/or a lesser restrictive intervention be effective.

C. The following interventions are prohibited:
1. Seclusions;
2. Aversive procedures involving electric shock (excluding medically administered electroconvulsive therapy); corporal punishment or interventions that cause physical pain or harm to a participant; unpleasant tasting foodstuffs or stimuli; and use of any noxious substances for the purpose of reducing a behavior.
3. Restraints that are prone, supine, restrict circulation or ability to breathe and/or excessive pressure on chest, lungs, sternum, and diaphragm, cause pain or harm to the participant; restraint chairs or boards; any maneuver that involves punching, hitting, poking, or shoving the participant; straddling or sitting on the torso any technique that restrains a participant vertically against a wall or post face first; and head hold where the head is used as a lever to control movement of other body parts.
4. Interventions involving: verbal or demonstrative harm caused by oral or written language, gestures with disparaging or derogatory implications; psychological/mental/emotional harm caused by unreasonable confinement, intimidation, humiliation, harassment, threats of punishment or deprivation; denial of food or beverage as a consequence of behavior; disabling of or restriction of a communication device; placing a participant in a room with no light; overcorrection; and withholding or taking away money, incentives or activities previously earned.

Requirements concerning the use of alternative strategies to avoid the use of restraints:
The DOH/DDD promotes positive behavioral supports, eliminating restrictive and adverse procedures, supporting Waiver participants to be fully integrated into the community and having meaningful lives. BSPs must have a hierarchical strategy of interventions that start with the least restrictive intervention possible and only in emergency situations of threat or harm to self or others. Service Supervisors and Staff who work directly with participants with identified behavioral challenges requiring a BSP must be trained in a nationally-recognized training program approved by DOH/DDD. A component of the curriculum must include de-escalation and re-direction techniques to be utilized prior to a restraint. It must also include focusing on the participant's needs, the physical environment to provide alternatives to escalating behaviors. Staff must be trained on the participant's Behavioral Support Plan containing individualized and specific techniques to safely resolve situations and minimize restraints.

Unauthorized or misapplication of restraints are detected through the following methods:
A. All defined restraints are reported through the Adverse Events Reporting (AER). All reports are monitored by the DOH/DDD for unauthorized use of restraints, seclusions, misapplication or abuse and may require corrective action;
B. Quarterly monitoring by DOH/DDD case managers who are required to meet with the participant, review recent events and observe their interactions with staff;
C. The complaint and grievance process identifies any violation of rights or unauthorized use of restraints;
D. Provider monitoring occurs annually or when any violations of standards are detected. Annual monitoring includes review of records and direct discussions with Waiver participants;
E. Annual on-site Certification Reviews of each adult foster home; and
F. Case review of sample of cases to detect unauthorized use of restraints by DOH/DDD Clinical Intervention Team (CIT), who provides recommendations to prevent the misuse of restraints.

Participants restrained frequently, injuries resulting from restraints and other events such as hospitalization, are referred to the Behavior Supports Review Committee (BSRC) per P&P 2.03. The BSRC reviews all aspects of care for the participant, recommends any additional assessments or information and advises on supports that could promote positive behavior. Current BSPs of any participants receiving a PRN medication for the purpose of behavioral control are reviewed by the BSRC. All provider agencies must have an internal policy that includes the use of restraints in alignment with the State's policy, the reporting of any use of restraints, and how unauthorized use or in application of restraints are detected and remediated.

The protocols that are followed when restraints are employed (including the circumstances when they are permitted and when they are not) and how their use is authorized:
DOH/DDD has a protocol for the use of restraints. Restraints may only be used when the following are in place:
- there is an imminent risk of harm to the participant or others;
- the professional writing the BSP possesses the required education and training;
- the participant and/or guardian (if applicable) has given informed consent to BSP;
- any staff involved in restraint must have documentation of being trained in positive behavior supports; the participant's BSP and a nationally recognized crisis intervention system approved by DOH/DDD;
- the participant's BSP outlines the hierarchy of least restrictive interventions, and are utilized and found to be ineffective prior to the use of restraint;
- the participant's BSP outlines the conditions that will indicate to staff that a restraint should be removed and a less restrictive intervention utilized;
- service supervisors trained in a nationally recognized crisis intervention system will facilitate debriefing of any use of restraint.

Restraints are not permitted when other less restrictive interventions would be effective; an imminent risk of harm to self or others is no longer present; or as a form of punishment.

The practices that are employed in the administration of a restraint to ensure health and safety:
Restraints are used only in emergency situations of imminent risk to self or others. The health and safety risk of the behavior must outweigh the risk of the restraint. The participant being restrained must be monitored throughout the use of restraint for health and safety. Monitoring includes continuous evaluation of the participant, including breathing, consciousness and effects such as pain; the participant's reaction to the restraint; the participant's behavioral condition; and, the need to terminate the restraints. Restraints are terminated immediately if there are any indications of health or safety risk and/or the earliest time safely possible.

Required documentation:
Providers shall maintain a record of the date, time, duration and antecedent of any restraint, evidence the provider first utilized positive and less restrictive interventions and that these interventions were not successful in deterring threat of harm. Records shall be shared with the case manager and participant's support team. Details will be communicated to DOH/DDD through the AER process.
Psychotropic PRN medications require the same documentation requirements as physical restraints and must also include documentation of the medication, dosage, behavior after administration, and side effects if present.
Education and training requirements that a provider agency personnel must meet who are involved in the administration of a restraint:
Providers must show documentation of staff having training in the participant's individual BSP; positive behavioral supports introduction and overview; and nationally recognized crisis intervention system approved by DOH/DDD.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Both DHS/MQD and DOH/DDD are committed to ensuring that the use of restraints and seclusion are only used to protect the participant from immediate harm to self and others. DOH/DDD is responsible for overseeing the use of restraints by waiver service providers. Information on any incidence of seclusion or restraint is collected through the AER process. AER data on seclusion and restraints, including analysis of trends and patterns are reported quarterly by the DOH/DDD Outcomes and Compliance Branch to the BSRC, which completes a quarterly report and makes recommendations for quality improvement to the DOH/DDD Quality Assurance and Improvement Program (QAIP) Safety and Well-being Subcommittee of the QAIP Steering Committee Recommendations address programmatic, policy and/or systemic recommendations. BSRC, as a regularly reporter to through the QAIP process, and based on review of the data, develops performance measures related to the use of restraints as part of the QAIP Work Plan.

Issues related to provider agency performance are referred by the DOH/DDD/OCB or the BSRC to the

DOH/DDD Provider Monitoring Section. If the issue requires an improvement plan or immediate corrective actions, the provider monitoring section requests, tracks and evaluates the implementation of improvement activities by the provider agency for effectiveness and addressing any core performance issues.

On an annual basis, DOH/DDD Certification Unit provides comprehensive monitoring of DOH/DDD Adult Foster Homes (AFH) as part of its certification process. The certification process involves records and on-site review of each AFH. Any incidents of seclusion or unauthorized use of restraints are cited for non-compliance with standards and corrections must be made. If any reports are made to the Certification Unit outside of the annual on-site inspection, Certification Unit staff conducts an investigation, and acts on any non-compliant practices to include requiring corrective actions.

The BSRC reviews individual cases with the highest rates of restraints and provides technical and clinical advice. The BSRC will look at trends to assist in necessary improvement. AER data on restraints is gathered on an ongoing and continuous basis. The Branch Chief for the Outcomes and Compliance Branch receives all reports of serious issues, and can implement investigations, request information, or intervene immediately if serious violations of DOH/DDD's standards are detected. Aggregate data are analyzed and reported quarterly to the BSRC who reports to the Safety and Well-being Committee of the QAIP Steering Committee. The BSRC analyzes, reviews data and makes recommendations quarterly. The Community Resource Branch conducts continuous provider monitoring basis, and site visits and conducted to each service site at least annually. As part of the annual monitoring visit, the process includes a review of a sample of records to identify any events, such as the use of restraints that were not reported as required. The provider must complete a corrective action plan (CAP) to address the participant-specific situation and revised policy, practice or other strategies the provider agency will employ to prevent further issues.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions.** *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

**i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

First use of non-aversive methods:
The DOH/DDD promotes the concepts of positive behavioral support and is focused on eliminating restrictive and adverse procedures, supporting people we serve to be integrated into the community and living meaningful lives. A positive approach assumes that all behavior has a purpose and that participant's behavior can be to communicate a need or a manifestation of a medical or clinical issue such as trauma.

Behavior support plans (BSP) with restrictive interventions are written to be proactive and minimize the occurrence of challenging behaviors via a primary focus on the use of positive interventions. Restrictive interventions are used only after lesser restrictive interventions have been attempted first and found not

effective. All restraints must be a part of a Behavior support plan with a hierarchical strategy of interventions starting with the least restrictive.

The following interventions are prohibited:
1. Seclusions;
2. Aversive procedures involving electric shock (excluding medically administered electroconvulsive therapy); corporal punishment or interventions that cause physical pain or harm to a participant; unpleasant tasting foodstuffs or stimuli; and use of any noxious substances for the purpose of reducing a behavior;
3. Restraints that are prone, supine, restrict circulation or ability to breathe and/or excessive pressure on chest, lungs, sternum, and diaphragm, cause pain or harm to the participant; restraint chairs or boards; any maneuver that involves punching, hitting, poking, or shoving the participant; straddling or sitting on the torso any technique that restrains a participant vertically against a wall or post face first; and head hold where the head is used as a lever to control movement of other body parts;
4. Interventions involving: verbal or demonstrative harm caused by oral or written language, gestures with disparaging or derogatory implications; psychological/mental/emotional harm caused by unreasonable confinement, intimidation, humiliation, harassment, threats of punishment or deprivation; denial of food or beverage as a consequence of behavior; disabling of or restriction of a communication device; placing a participant in a room with no light; overcorrection; and withholding or taking away money, incentives or activities previously earned.

Staff who provide services to participants whose treatment plans include restrictive intervention(s) are trained in a nationally-recognized curricula approved by the DOH/DDD. A component of these curricula includes de-escalation and re-direction techniques to be used prior to a restraint as well as crisis management and intervention techniques. In addition, staff must be trained on the participant's behavioral support plan which focuses on utilizing non-aversive methods as a primary intervention.

Methods to detect the unauthorized use of restrictive interventions:
DOH/DDD employs multiple ways of detecting and addressing unauthorized use of restrictive interventions. All unauthorized restrictive interventions are reported and addressed through the AER process. Case managers monitor aversive methods in routine meetings with participant and report any suspected abuse or neglect. The BSRC reviews cases of people who have experienced injuries due to restrictive interventions and take referrals for people with behaviors that are difficult to manage. Unauthorized restrictive interventions may also be detected through the complaints and grievance process. Provider monitoring is another method to detect unauthorized use.

On an annual basis, DOH/DDD Certification Unit provides comprehensive monitoring of DOH/DDD Adult Foster Homes (AFH) as part of its certification process. The certification process involves records and on-site review of each AFH. Incidents of unauthorized use of restrictive interventions are cited for non-compliance with standards and corrections must be made. If any reports are made to the Certification Unit outside of the annual on-site inspection, Certification Unit staff conducts an investigation, and acts on any non-compliant practices to include requiring corrective actions.

Protocols for authorizing the use of restrictive interventions, including treatment planning requirements and review/reauthorization procedures:
All BSPs must follow guidelines on prohibitions of specified aversive methods and restrictive interventions. BSPs with specified restrictive interventions must have the informed consent of the participant, guardian (if applicable) and/or treatment team. BSPs are required to promote positive and proactive strategies to avoid restrictive procedures. Samples of BSPs are reviewed in provider monitoring for quality and compliance with state policy. Any BSP that includes a restrictive intervention for waiver participants with identified behavioral challenges that required a BSP is reviewed by the BSRC.
Required documentation when restrictive interventions are used:
To assess the efficacy of BSPs that are being implemented, the documentation of behaviors, circumstances, restrictive interventions and effectiveness in addressing each incidence of targeted behaviors are needed. Adequate documentation is a key component of being able to monitor behaviors and evaluate efficacy of interventions for future BSP modification and improvement. BSPs should utilize documentation as a means of tracking progress and working toward the elimination of restrictive interventions for participants served by the DOH/DDD.

Education and Training:
Providers must show documentation of agency personnel having training in the following: the participant's individual BSP; Positive behavioral supports introduction and overview; and nationally accredited crisis intervention system approved by DOH/DDD.

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Information on any incidence of unauthorized restrictive interventions including restraints and seclusions are collected through the AER process. AER data unauthorized restrictive interventions, including analysis of trends and patterns are reported quarterly by the DOH/DDD Outcomes and Compliance Branch (OCB) to the BSRC, which completes a quarterly report and makes recommendations for quality improvement to the DOH/DDD Quality Assurance and Improvement Program (QAIP) Safety and Well-being Subcommittee of the QAIP Steering Committee Recommendations address programmatic, policy and/or systemic recommendations. BSRC, as a regularly reporter to through the QAIP process, and based on review of the data, develops performance measures related to the use of restraints as part of the QAIP Work Plan.

Issues related to provider agency performance are referred by the OCB or the BSRC to the DOH/DDD Provider Monitoring Section. If the issue requires an improvement plan or immediate corrective actions, the provider monitoring section requests, tracks and evaluates the implementation of improvement activities by the provider agency for effectiveness and addressing any core performance issues.

The BSRC reviews individual cases with the highest rates of unauthorized restrictive interventions including restraints and provides clinical recommendations. The BSRC will look at trends to assist in provider improvement and consultation with Training and Consultation to identify areas to address.

AER data on unauthorized restrictive interventions including restraints is gathered on an ongoing and continuous basis. The Branch Chief for the Outcomes and Compliance Branch receives all reports of serious issues, and can implement investigations, request information, or intervene immediately if serious violations of DOH/DDD's standards are detected. Aggregate data are analyzed and reported quarterly to the BSRC who reports to the Safety and Well-being Committee of the QAIP Steering Committee. The BSRC analyzes, reviews data and makes recommendations quarterly. Provider monitoring is conducted on a continuous monitoring basis, and site visits are conducted to each service site at least annually.

As part of the annual monitoring visit, the process includes a review of a sample of records to identify any events such as the use of restraints that were not reported as required. The provider must complete a corrective action plan (CAP) to address the participant-specific situation and revised policy, practice or other strategies the provider agency will employ to prevent further issues.

# Appendix G: Participant Safeguards

## Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

**c. Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

DOH/DDD P&P # 2.02 Restrictive Procedures prohibits the use of seclusion. DOH/DDD is responsible for detecting the unauthorized use of seclusions and any use of seclusion is required to be reported as an AER. Incidents that are seclusions are coded as such to put an emphasis on detection and oversight of this prohibited

practice. Seclusion can also be detected in provider monitoring. The BSRC will review cases where seclusion is occurring and provide clinical recommendations on alternative methods to implement for the purpose of discontinuing the use of seclusion.

Seclusions are detected through the following methods:
A. All seclusions are reported through the Adverse Events Reporting (AER) system. All reports are monitored by the DOH/DDD for unauthorized use of seclusions require corrective action;
B. Routine quarterly monitoring by DOH/DDD case managers who are required to meet with the participant, review recent events and observe their interactions with staff and others;
C. The complaint and grievance process identifies any violation of rights or unauthorized use of seclusions;
D. Provider monitoring of performance occurs at least annually, and when any violations of standards are detected. Annual monitoring includes review of records, and direct discussions with Waiver participants;
E. On-site Certification Reviews of each adult foster home which is performed annually; and
F. Case review looking at a sample of cases to detect unauthorized use of seclusions by the DOH/DDD Clinical Intervention Team (CIT) who provides recommendations to case managers on alternative methods to prevent the use of seclusion.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
◉ **Yes. This Appendix applies** *(complete the remaining items)*

**b. Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

For all individuals:

The DOH/DDD case manager, as part of their assessment/reassessment and monitoring responsibilities, reviews the individual's records in a certified or licensed setting when home visits are done. DOH/DDD policy is that the case managers are required to make at least one home visit annually.

For individuals receiving medications as part of waiver services, the service supervisor (registered

professional nurse) is expected to comply with the Nurse Practice Act; quarterly service reports should include confirmation of medications administered. The DOH/DDD service supervisor will communicate with the Primary Care Provider (PCP), as necessary.

AERs identifying medication administration problems are submitted and reviewed by DOH/DDD and monitored by DHS. Follow up actions are made as necessary, including increased monitoring and/or training requirements.

The DOH/DDD Clinical Interdisciplinary Team (CIT) is available to discuss issues and concerns with medication issues, including polypharmacy, chemical restraints, etc. All cases identified as potentially at risk, e.g., polypharmacy, psychotropic usage, challenging behaviors, will be brought forth for discussion.

**ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

a) For certified and licensed residential settings, the DOH/DDD certifying/licensing staff is responsible for the annual reviews to ensure that participant medications are managed appropriately by the certified/licensed caregiver. As part of the review, the certifying/licensing staff reviews the participant's home records, home operational practices regarding medications and health areas in terms of compliance with regulations, e.g., storage, physician's orders, administration, disposal of medications, including medical reports, medication errors, and medication administration flow sheets. If staff identifies any problems or concerns, follow up actions may include: a) informing the case manager of such concerns and requesting assistance with follow-up of participant's physician, guardian (if applicable), etc.; b) citation and requirement for plan of correction; c) referral for DOH/DDD follow up. The certifying/licensing staff will follow up on corrective actions taken (or not taken) and may pursue continued certification/licensure, probation, or termination of license or certificate.

b) AERs identifying those areas of potentially harmful practices are tracked to ascertain appropriate follow up action. This may include training, consultation sessions, sanctions, etc. Follow up of CIT reviews will also be done to ensure both appropriate follow up on individual situations and to identify system needs for training, consultation, or information sharing with community physicians.

c) Both DOH/DDD and DHS/MQD will collaborate on follow up and oversight. DHS/MQD is responsible for overseeing that critical events are reported and satisfactorily addressed and resolved. The oversight includes a review of quarterly AERs summary reports submitted by DOH/DDD as well as a detailed review of any AER involving a death and AERs in participants and/or providers for which a trend has been identified. Both DOH/DDD reviews and DHS/MQD oversight together comprise aggregation and analysis of 100% of AERs received. DOH/DDD will work on remediation with waiver providers and DHS/MQD will work with DOH/DDD on remediation and system(s) change(s).

# Appendix G: Participant Safeguards

## Appendix G-3: Medication Management and Administration (2 of 2)

**c. Medication Administration by Waiver Providers**

**i. Provider Administration of Medications.** *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

**ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws,

regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver providers who administer medications as part of waiver services can only do so with a physician's order and by a registered nurse or as part of nurse delegation.

Medications
1) The following shall apply to medications ingested or administered during the hours the participant is in Waiver Program or Waiver Program services from a provider:
a) physician prescribed medications may be self-administered by a participant when the participant is physically and cognitively able to do so;
b) the participant may self-inject prescribed medications when the physician has written orders to permit this; and
c) the participant may be supported with medication administration when:
1) the medication has been pre-measured;
2) the medication is in individual doses;
3) the container is clearly labeled by the participant's caregiver, pharmacist, physician, RN or LPN with the participant's name and the time and route for the medication; and
4) the participant is able to take the single dose of medication independently. The provider staff assisting with the medication shall not place the medication in the participant's mouth.

2) Assistance with medication includes, but is not limited to, the following:
a) placing the labeled container with the pre-measured medication in the participant's hand;
b) assisting the participant with opening the container and dropping the medication into the participant's hand when needed;
c) instructing the participant to take the medication;
d) helping the participant to drink a liquid in order to swallow the medication;
e) watching and observing the participant to ensure that the medication has been swallowed; and
f) documenting the assistance with medication in the participant's chart.

3) The participant's record shall include the following information for each prescribed medication that the participant will take during the provider's service hours:
a) general information on recommended dosages and the medication's effect;
b) instructions for participant monitoring;
c) potential drug or food interactions; and
d) the provider shall follow the procedures for reporting Adverse Events (see provider Continuous Quality Assurance) observed by the provider, including medication errors and unexpected reactions to drugs or treatment, as specified in the standards.

**iii. Medication Error Reporting.** *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
*Complete the following three items:*

(a) Specify State agency (or agencies) to which errors are reported:

All medication errors must be reported as an adverse event report. Such reports are sent to DOH/DDD for review.

(b) Specify the types of medication errors that providers are required to *record:*

All medication errors – missing a dose, giving a wrong dose at the wrong time or to the wrong individual, not complying with physician's orders, adverse reactions to medications (over the counter and prescribed), unexpected reactions to drugs or treatment - must be reported as an adverse report. Such reports are sent to DOH/DDD for review.

(c) Specify the types of medication errors that providers must *report* to the State:

All medication errors and unexpected reactions to drugs or treatment.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DOH/DDD staff review reports of medication errors and follow up as necessary on corrective action. Medication errors and unexpected reactions to drugs or treatment by the provider agencies are reported using the AER form. Data is collected and summarized to identify trends, remediation, and opportunities for system improvement, such as additional training for provider or a medical assessment for the participant or a change in DOH/DDD policy. DHS/MQD receives and reviews a summary of the AER reports quarterly.

Providers submit medication errors on an AER form. Copies of all adverse events reports are submitted to DOH/DDD for review. The reports are logged into the DOH/DDD database, tracked, and trended. Remediation activities are identified and followed-up as a result of each AER. DOH/DDD follows guidelines that are issued by DHS/MQD and follows established policies and procedures.

DHS/MQD is responsible for overseeing that all adverse events, including all medication errors, are reported and are satisfactorily addressed and resolved. An overview of this oversight includes:

1) review of quarterly AER Summary Reports submitted by DOH/DDD, which will comprise of an aggregation and analysis of 100% of AERs received. DHS/MQD will notify DOH/DDD if further remediation, corrective action, or system improvement is needed;
2) detailed review of AER Reports for all deaths; and
3) detailed review of AER Reports for participants or providers that raise concerns based on monitoring trends.

All waiver providers are required to have an Internal Quality Improvement program that includes a process that provides for ongoing monitoring, quarterly assessment and trending of Adverse Events for appropriateness of action taken, follow-up and preventive actions to be taken.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Health and Welfare**
***The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.*** *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

**i. Sub-Assurances:**

**a.** ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% of adverse event reports (AERs): By provider; participant; and type. N: # of adverse event reports (AERs): By provider; participant; and type. D: Total # of AERs submitted**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**AER summary report**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| | |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#/% of AERs with an appropriate immediate action by provider agency/CDPA/caregiver of licensed or certified home to safeguard participant as assessed by the DOH/DDD case manager. N: # of AERs with an appropriate immediate action by provider agency/CDPA/caregiver of licensed or certified home to safeguard participant as assessed by the DOH/DDD case manager D: Total # of applicable AERs**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**AER Summary Report**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#/% of deaths that required follow-up for which follow-up was completed. N: # of deaths that required follow-up for which follow-up was completed D: Total # of deaths that required follow- up as determined by the DDD Mortality Review Committee**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**AER Summary Report**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other** | ☐ **Annually** | ☐ **Stratified** |

| | | |
|---|---|---|
| Specify: | | Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% Number and percent of AERs initiated by the provider agency/CDPA and reported within required time frame (Verbal report DOH/DD CM within 24 hours, Written report to DOH/DDDCM within 72 hours) N: # of AERs initiated**

**by the provider agency/ CDPA reported within required time frame D: Total # of applicable AERs submitted**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**AER Summary Report**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**#/% of AERs with an appropriate plan of action, by the provider agency/CDPA/caregiver of licensed or certified home to prevent recurrence of adverse event as assessed by case manager N: # of AERs with an appropriate plan of action by the provider agency/CDPA/caregiver of licensed or certified home to prevent recurrence of adverse event as assessed by case manager D: Total # of applicable AERs**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**AER Summary Report**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% of prohibited restrictive interventions that resulted in an AER N: # of prohibited restrictive interventions that resulted in an AER in accordance with policies and procedures D: all prohibited restrictive interventions**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**AER Summary Report**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** |

| | | |
|---|---|---|
| | | Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☑ **Other** Specify: sample of records by monitoring team looking for restrictive interventions that should have been reported but weren't |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**d.** ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% of participant records documented the provider implemented practices in accordance with the Waiver Standards that achieve outcomes related to health care management and oversight N: # of participant records documented the provider implemented practices in accordance with the Waiver Standards that achieve outcomes related to health care management and oversight D: Total # of records reviewed**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Record review**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample** Confidence Interval = |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DOH/DDD is responsible for reviewing all adverse or critical event reports and ensuring that each adverse event is addressed and resolved appropriately. If remediation is needed, DOH/DDD confirms the completion and documentation of the remediation activities. For service provider agencies, remediation activities may include re-training of its staff and increasing the frequency of on-site quality reviews by DOH/DDD. On a quarterly basis, DOH/DDD submits the Adverse Events Reporting Summary Report to DHS/MQD which includes a summary of each adverse event report, the remediation activities and results of the performance measures listed in the previous section. This report is reviewed and analyzed by DHS/MQD to aid in identifying trends and need for systems improvement.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | |

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3)

the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 2)

### H-1: Systems Improvement

**a. System Improvements**

**i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The DHS/MQD Quality Strategy was approved by CMS in State Fiscal Year 2011. It is a comprehensive strategy that includes the monitoring of Home and Community-Based Services and is the framework for monitoring of the waiver. The strategy describes implementation of a Quality Flow Process, which ensures reviewing of monitoring reports followed by immediate remediation, trending, prioritizing, and implementing system changes.

DHS/MQD receives and reviews all quarterly monitoring and quality reports from the DOH/DDD. Standardized reporting and review tools have been developed to allow for improved oversight and trending over time. Findings from the reports will be presented to the Quality Strategy Committee as the reports are received and reviewed according to a monitoring calendar. The Committee is comprised of representatives from the Quality Strategy Leadership Team, technical experts for the waiver, and the reviewer(s). The committee meetings represent a formal process for the analysis of data received, root causes, barriers, and improvement interventions. The Committee will recommend feedback to the DOH/DDD, and corrective action will be requested if needed. Findings and recommendations will be properly documented. The Leadership Team will also meet quarterly to review the findings and recommendations from the Committee, analyze trends, and set priorities, focusing on critical and high impact issues requiring system(s) change(s) that relate to meeting established goals and objectives. At least semi-annually and as needed, the Leadership Team will meet collaboratively with DOH/DDD. These Quality Collaboratives will allow opportunity of dialogue, feedback, follow-up of corrective actions, exchange of information, and identification of best practices.

**ii. System Improvement Activities**

| **Responsible Party***(check each that applies):* | **Frequency of Monitoring and Analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☑ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Quality Improvement Committee** | ☐ **Annually** |
| ☐ **Other** Specify: | ☐ **Other** Specify: |

| **Responsible Party***(check each that applies):* | **Frequency of Monitoring and Analysis***(check each that applies):* |
|---|---|

**b. System Design Changes**

**i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

DHS/MQD
A Quality Strategy Leadership Team meets regularly to review the findings and recommendations from Quality Strategy Committees. The Leadership Team will also meet collaboratively with DOH/DDD on a regular basis to allow for dialogue, feedback, and follow-up of corrective actions, performance improvement projects, exchange of information, and identification of best practices. System improvements will be identified and monitored as a result of these collaborative reviews of monitoring trends, results of remediation, and best practices. The following shows a summary of the Quality Strategy Oversight.

Summary of the Quality Strategy Oversight (entities, membership and responsibilities):

Entity: Quality Strategy Leadership Team (QSLT)
Membership:
- DHS/MQD leadership from several branches and offices;
- DHS/MQD Medical Director or Physician Designee; and
- External Quality Review Organization (EQRO) consultant as needed.
Responsibilities:
- lead the development, review, and revision of Quality Strategy;
- oversight for review of quality data and monitoring reports;
- oversight for quality improvement recommendations and implementation of these recommendations by the waiver program;
- meets quarterly and more often as needed; and
- meets semi-annually in Collaboratives with the waiver program.

Entity: Quality Strategy Committees (QSC)
Membership:
- QSLT representative;
- DHS/MQD technical expert(s) in the waiver; and
- DHS/MQD HCBS reviewer(s)
Responsibilities:
- committees include the waiver committee;
- review of quality data and monitoring reports from the waiver program;
- recommendations for corrective actions, quality improvement, and system changes;
- follow-up of corrective actions and quality improvement recommendations; and
- meets in a monthly rotation.

Entity: Quality Collaboratives
Membership:
- QSLT representative(s);
- DHS/MQD technical expert(s);
- DOH/DDD Waiver program representative(s); and
- EQRO consultant if needed.
Responsibilities:
- serves as forum between DHS/MQD and the waiver program for dialogue, feedback, follow-up of corrective action, performance improvement projects (PIPs), and best practices; and
- meets semi-annually.

DOH/DDD
DOH/DDD has implemented a Quality Assurance and Improvement Program (QAIP) to ensure the

systematic monitoring of all services and supporting service infrastructure. It has a formal program description, work plan with performance measures, and a committee structure. The QAIP Steering Committee oversees the implementation of the QAIP and is chaired by the DOH/DDD Medical Director. Three subcommittees meet on a quarterly basis to receive and review reports and data: the Quality Services and Care Subcommittee, the Utilization/System Integration Review Subcommittee, and the Safety and Well-being Subcommittee. Key committees operate under the Subcommittee structure, including the Mortality Review Committee that reviews deaths of every participant, and reports to the Safety and Well-being Subcommittee, The QAIP is evaluated and revised on an annual basis, with annual goals and objectives. The DOH/DDD Management Team provides approval of recommendations from the QAIP Steering Committee and can assign Improvement Teams to design programmatic quality improvements. DOH/DDD also operates several standing committees including the Utilization Review Committee (URC) that reviews appropriate use of services and makes recommendations for adjustment, approval, or denial of services, and the Clinical Interdisciplinary Team (CIT) that reviews and makes recommendations regarding clinical issues.

DOH/DDD, with representation from DHS/MQD, conducts regular quarterly meetings with the Waiver Policy Advisory Committee (PAC). This group includes participants, families, providers, DD Council, Hawaii Disability Rights Coalition, the Center for Disability Studies at the University of Hawaii-Manoa and DOH/DDD staff. Any changes to the waiver, including changes related to quality monitoring, are discussed in these stakeholder meetings. In addition, DHS/MQD maintains a website that will hold information about the waiver program, including performance on quality monitoring.

**ii.** Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Strategy is a dynamic system, which both DHS/MQD and DOH/DDD continual review to assess the effectiveness of the waiver monitoring. The Quality Strategy, including DOH/DDD monitoring, will be reviewed at least annually by the Quality Strategy Leadership Team and revised, if necessary. However, the Quality Strategy Committees may suggest changes to the Leadership Team throughout the year that will be reviewed to identify whether a suggested change necessitates a review and revision of the Quality Strategy sooner than the appointed time. At each review and revision of the strategy, the Leadership Team will determine whether the changes made to the Quality Strategy are significant enough to require additional stakeholder input and a public comment period. Significant changes are changes that may impact quality activities and/or threaten the potential effectiveness of the Quality Strategy. At least once every five (5) years, unless significant changes dictate a sooner timeframe, a 30-day public comment period will be made available.

The Quality Strategy is reviewed with criteria such as: a) ongoing validity of data; b) extent to which the discovery data is actionable; c) efficiency of data collection; d) utility and frequency of monitoring reports; e) utility of remediation efforts; and f) need for addition of other measures and data gathering methods based on identified trends and priorities.

The Quality Strategy is also reviewed to ensure that system(s) change(s), e.g. policy changes, training, technical assistance, etc. are effective. The Quality Committees and Leadership Team will regularly review and assess system(s) change(s) to ensure implementation and effectiveness in the light of measurement trends. DHS/MQD and DOH/DDD discuss the implementation and effectiveness of system(s) change(s) in regular Collaborative meetings.

A Work Plan is written annually to supplement the Quality Strategy during the annual review and revision process. Part of the Work Plan includes a specific section on any revisions to waiver monitoring. The development of the Work Plan specific to waiver monitoring begins with an assessment of accomplishments and challenges from the previous year's Work Plan and summary analyses/input from the Quality Strategy Committee's review of monitoring reports. The Work Plan development also incorporates input from other sources such as the DOH/DDD, the Waiver PAC, the managed care health plans, participants, providers, partner government agencies, and stakeholders. The Work Plan will clearly document the effectiveness of the Quality Strategy by summarizing successes and challenges as well as interim performance results. The Work Plan also outlines areas of focus for quality activities, such as quality improvement measures, improvement projects, and performance indicators.

## Appendix I: Financial Accountability

## I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a) Provider agencies that bill for services in excess of $750,000 shall be responsible to procure an annual end-of-the year audit conducted by an independent CPA.

b) The DOH/DDD Fiscal Office reviews all waiver providers at least annually using on-site reviews and desk audits of records. For each provider, the DOH/DDD Fiscal Office selects a statistically valid random sample of the participants served during a one-year period. For the participants selected for review, the DOH/DDD Fiscal Office reviews the ISP to ensure the services were authorized (service level and number of units) and compares the paid claims information (from HPMMIS, the Medicaid MMIS) against the authorized services. The DOH/DDD Fiscal office verifies that the service code and units billed and payment match the authorizations. The DOH/DDD Fiscal Office verifies timesheets signed by the provider of services, reviews attendance logs and examines other records, as appropriate, to ensure the documentation supports the claim billed by the provider. If necessary, the DOH/DDD Fiscal Office may contact the participant or his/her representative to verify the delivery of services by the provider agency.

c) DHS/MQD delegates the financial reviews to the DOH/DDD and provides oversight of delegated responsibilities through review of quarterly monitoring reports. The DOH/DDD submits a report detailing the findings of each provider review to DHS/MQD. Any cases requiring remediation and/or follow-up action will be handled by the DOH/DDD. In addition, the DHS/MQD validates a sample of DOH/DDD provider on-site reviews at least annually.

Every provider that receives $750,000 or more in Medicaid funds during a year is required by the Waiver Standards to perform an independent financial audit by a CPA agency and submit the audit to the State for review. If inconsistencies are noted, the State will request additional information. In addition to the independent audit, the DOH/DDD fiscal office staff who are accountants conducts annual audits of a sample of records following a procedure similar to the PERM audit and will recoup Medicaid funds paid without proper supporting documentation. The State had its PERM audit last year and of all DD waiver provider records sampled, only one claim was found to be out-of-compliance, which is an extremely high rate of accuracy.

# Appendix I: Financial Accountability

## Quality Improvement: Financial Accountability

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

a. **Methods for Discovery: Financial Accountability Assurance:**
***The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.*** *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
    i. **Sub-Assurances:**

        a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

            **Performance Measures**

            *For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% of waiver participants who received services that were authorized and payment for those services is supported by the appropriate documentation N: # of waiver participants who received services that were authorized and payment for those services is supported by the appropriate documentation D: Total # of participant reviewed in the quarter**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**DOH/DDD Fiscal Section Audit**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☐ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☑ **Representative Sample** Confidence Interval = 95% |
| ☐ **Other** Specify: | ☐ **Annually** | ☐ **Stratified** Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other** Specify: |
| | ☐ **Other** Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**#/% of payments made that are consistent with the established rate methodology.**
**N: # of claims that were paid the appropriate rate D: Total # of payments**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Conduent report**

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☑ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |

| | | |
|---|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis***(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DHS/MQD identifies individual problems through quarterly reports received from its fiscal agent and DOH/DDD. For claims not paid in a timely manner, technical assistance is provided to the fiscal agent to improve timely processing of claims. For a claim paid with a cost share error or for a suspended participant, remediation is specific to the problem, i.e. incorrect suspension dates inputted or cost share information not

provided and payment is recouped. In addition, DHS shall provide training to DOH/DDD as needed to assure that financial processes are managed correctly.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party***(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other** Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other** Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (1 of 3)

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rate determination and oversight is a joint responsibility between the Department of Health's Developmental Disabilities Division (DDD) and the Department of Human Services' Med-QUEST Division.

Waiver services are reimbursed on a prospective, fee-for-service basis, with the exceptions noted below for items and services that are procured and manually priced. With the assistance of Burns & Associates, Inc., a national consultant experienced in developing provider reimbursement rates for HCBS waivers, DDD has recently completed a comprehensive review of payment rates.

The rate study considered both existing services and new services being added to the waiver in order to enhance participants' supports for full community integration. The State will begin phasing in the resultant new fee schedule on July 1, 2017.

The rate study included:

-A series of meetings with a Provider Advisory Group. The group was comprised of a diverse cross-section of providers in terms of services delivered, size, and location. The group was convened at key milestones in the study, including development of a draft provider survey and consideration of survey results.

-Development and administration of a provider survey related to service design and costs. All providers were sent the survey and given an opportunity to participate. Burns & Associates provided technical assistance throughout the survey period, including drafting detailed instructions for completing the survey, recording and posting online a webinar to walk-through the survey, responding to questions via phone calls and emails, reviewing each submitted survey and working with providers to resolve potential errors. The provider survey informed the rates for both existing and 'new' services because most of the new services are spin-offs of existing services (for example, Community Learning Service is essentially Personal Assistance/ Habilitation and Adult Day Health services provided in the community; Residential Habilitation is PAB being delivered in a licensed or certified settings).

-Identification of benchmark data, including Bureau of Labor Statistics cross-industry wage and benefit data as well as rates for comparable services in similar programs.

-Development of rate models for each service that include specific assumptions related to the various costs associated with delivering each service, including direct care worker wages, benefits, and 'productivity' (i.e., billable time); staffing ratios; mileage; facility expenses; and agency program support and administration. Development of rate models for participant-directed services followed the same approach although individual assumptions may differ (for example, the participant-directed rate models include lesser amounts for employee benefits and do not include agency overhead costs) and the rates are based on an allowable range of wages the employer can pay the employee.

-Incorporation of Supports Intensity Scale (SIS) assessment data to create 'tiered' rates for Residential Habilitation, Adult Day Health, and Community Learning Service-Group to recognize the need for more intensive staffing for individuals with more significant needs. In particular, the State has adopted a SIS-based seven level framework using assessment criteria employed in several other states. These seven assessment levels were grouped into three rate tiers. The models for each tier incorporate different staffing ratios (with more intensive staffing necessitating a higher rate), reflecting the DDD's expectations for support.

-Analysis of travel distances across the islands, which resulted in the new fee schedule incorporating generally higher rates for services delivered on the Big Island in order to account for greater travel-related expenses in terms of both mileage and staff time.

-A public comment process through which proposed rate models were emailed to providers and other stakeholders, and posted online. Interested parties were given several weeks to submit written comments. DDD prepared written responses to all comments received and revised the rates as appropriate.

DDD oversaw the work of the consultant and assumed ownership of the rate models so that they can be periodically reviewed and updated as necessary.

Rate models were developed for all waiver services with a few exceptions. The waiver rate schedule is available on DOH/DDD's website.

Rate models for the new Private Duty Nursing and Nursing Respite services were derived from the Skilled Nursing rate models established as part of the rate study with adjustments to account for expected differences in encounter lengths. Specifically, the Private Duty Nursing and Nursing respite rate models incorporate the same wage, benefit, and overhead assumptions as in the Skilled Nursing rate models, but less travel and more billable hours based on longer encounters (resulting in less travel and downtime).

For services provided by licensed behavior analysts and registered behavior technicians, the State benchmarked the rates for licensed behavior analysts and registered behavior technicians against those paid by TRICARE and Med-QUEST (the two systems pay the same rates for these services). Services in these programs are more likely to be clinic-based whereas waiver services will primarily be home- and community-based. Given the travel associated with home- and community-based services, professionals delivering waiver services will have fewer billable hours per day. Thus, the rates from these other programs were increased by 20 percent to account for fewer billable encounters, effectively assuming that clinic-based providers can deliver an average of six billable hours of service

per day while home- and community-based providers can deliver only five hours.

Specialized Medical Equipment and Supplies, Vehicular Modifications, Personal Emergency Response Systems and Assistive Technology services are reimbursed through manual pricing, up to the limits specified in the service description.

PERS has established rates that is based on the market costs for the installation and monthly monitoring services. The rate has remained the same for several years and the provider has not indicated a need to increase the rate.

Assistive Technology, Specialized Medical Equipment and Supplies, Vehicular Modifications, and Environmental Accessibility Adaptations are purchased following state of Hawaii procurement rules.

1. Purchase amount is less than $5,000, three (3) quotes required, award to the lowest bidder. If amount is $2,500 or more, bidder must present Certificate of Vendor Compliance (CVC) prior to awarding the contract;
2. Purchase amount is $5,000 but less than $15,000, three (3) written quotes required by using the State Procurement Office Form, small purchase, upon approval from the procurement officer, contract will be awarded to the lowest bidder who is required to present the CVC;
3. Purchase amount is $15,000 or more, HIePRO solicitation is required, award to the lowest bidder who present CVC prior to award the contract.

Once an award is made, the case manager enters the authorization for the lowest bid amount into the DOH/DDD system that is transmitted to the DHS/MQD fiscal agent. If the supplier is a waiver provider, the provider submits a claim through the DHS/MQD fiscal agent for payment after the item is delivered. This ensures that the lowest bid is the authorized amount and cannot be exceeded. If the supplier is not a waiver provider, reimbursement is processed by purchase order through the DOH/DDD fiscal office. The fiscal office ensures that the billed amount does not exceed the approved amount per the procurement rules. The DOH/DDD fiscal office then works with DHS/MQD for reimbursement of the FFP.

**b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All services, regardless of payment processing, are prior authorized by the DOH/DDD case managers.

1) Agency Provided Services
All waiver services are prior authorized by the DOH/DDD case managers and forwarded to the DHS/MQD fiscal agent. Waiver agency providers' claims processing/payment follows the State's Medicaid Fee-For-Service process. The DHS/MQD Fiscal Agent enters the prior authorizations into HPMMIS, the State's MMIS. Providers render the services and send their claims for the services to the DHS/MQD Fiscal Agent for processing. Providers have the option of submitting claims electronically or manually on a CMS 1500 form. The DHS/MQD Fiscal Agent provides an electronic HIPAA-compliant interface that enables providers to send claims electronically. If the providers want to file manual claims, the claims are sent to the DHS/MQD Fiscal Agent's office located on Oahu for processing. HPMMIS adjudicates claims on a daily basis and processes payments on a weekly basis. Prior to the checks being generated, the DHS/MQD Fiscal Agent will notify DHS/MQD of the funds required for the week's payment. DHS/MQD bills DOH/DDD for the required State funds portion on a weekly waiver basis. Checks are generated at the end of each week. Providers have the option of receiving their payment electronically (deposited directly into the provider's bank account) or by mail. Providers also have the option to receive their remittance advices electronically or by mail with the check.

2) Consumer Directed-Personal Assistance Option
The DHS/MQD limited fiscal agent performs payroll processing functions to pay claims for consumer directed personal assistance services. The invoice for the participant's employee's hours or days worked for the previous month is received by DOH/DDD. Following a review of the invoice, the information is inputted electronically to the limited fiscal agent for payroll processing. The limited fiscal agent sends a summary of the consumer directed personal assistance payments to the DHS/MQD Finance Office, which creates a bill of collection that is sent to DOH/DDD for payment of the state portion (non-federal share).

3) Environmental Accessibility Adaptations, Specialized Medical Equipment & Supplies that require unique pricing;

Vehicular Modifications, Assistive Technology,
Following the delivery of service, providers submit invoices to and are paid by DOH/DDD. The invoices are processed following the State of Hawaii Department of Accounting and General Services (DAGS) policies and procedures to generate a state purchase order. Quarterly, a file containing all the items paid for by DOH/DDD is submitted to DHS/MQD for Medicaid eligible waiver participants. Upon receipt, DHS/MQD sends a bill of collection to DOH/DDD for the state portion (non-federal share). DOH/DDD will then voucher the state share to DHS/MQD. DHS/DDD will pay DOH/MQD the total invoice at a later date. Subsequently, DHS/MQD will draw down the federal share from CMS.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

**c. Certifying Public Expenditures** *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (3 of 3)

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All services are identified in the participant's individual service plan; the DOH/DDD case manager prior authorizes before services are delivered and enter the authorized services into a calculator that is uploaded to reference table (procedure codes, modifiers, and payment rates) to the DHS/MQD fiscal agent.

a) Edits are in place to ensure that claims for payment are made only when the participant is eligible for Medicaid waiver payment on the date of service. The following describes the different claim methodologies.

1) Agency Provided Services

The DHS/MQD fiscal agent processes all provider agency claims. HPMMIS contains individual Medicaid eligibility information, reference tables of approved waiver services, (procedure codes, modifiers and payment rates), prior authorizations, and qualified provider information. All claims are adjudicated according to edit checks, e.g., participant is Medicaid eligible and "enrolled" in the waiver at the time of service. Based on system rules, HPMMIS denies claims that fail the edit checks, e.g., claim for a participant not Medicaid eligible on the date of service. HPMMIS generates paid claims reports to validate the claims for Federal reimbursement.

2) Consumer Directed-Personal Assistance option
These claims are paid outside of the HPMMIS system. DOH/DDD validates Medicaid eligibility on the date of service, reviews that the units of services are within the authorized amount in the participant's ISP, assures provider certification requirements are met and enters all information necessary to authorize payment directly into the contracted limited fiscal agent's electronic payroll system. DOH/DDD reviews and transmits the information to the limited fiscal agent for this payroll processing. This limited fiscal agent generates the summary of the consumer directed payments and the participant's checks for delivery to DOH/DDD for mailing to the participants. Submittal of the bill of collection is then routed to DOH/DDD for remuneration of the non-federal share of the payments.

3) Environmental Accessibility Adaptations, Specialized Medical Equipment & Supplies, Vehicular Modifications, Assistive Technology

If the provider is a Medicaid waiver provider, the provider submits a claim through the DHS/MQD fiscal agent (Conduent) for payment once the item is delivered or work is completed. If the supplier or vendor is not a waiver provider, reimbursement is processed after the work is completed by issuing a purchase order through the DOH/DDD fiscal office. The DOH/DDD Fiscal Office prepares a purchase order and processes the invoice for payment compliant with the DAGS policies and procedures. DAGS mails the check to the vendor. The DOH/DDD fiscal office then works with DHS/MQD for reimbursement of the FFP.

b) Edits are in place to ensure that claims for payment are made only when the service was included in the participant's approved service plan through a check against the prior authorization in the system, including service dates within the authorization period and using valid (the prior authorized code) procedure codes. Claims are priced using the rates in HPMMIS. If there is no prior authorization, the claim will be denied.

c) The annual claims audit performed by the DOH/DDD Fiscal Section staff is used to verify that the billed services were actually authorized in the service plan, provided by the provider, employee or vendor. If the DOH/DDD Fiscal staff identifies unsubstantiated or erroneous billings, the DOH/DDD Fiscal Office sends a formal letter to the provider, employee or vendor seeking recovery of the overpayment. In the case of claims, the DHS/MQD fiscal agent is able to adjust the claim and recoup the overpayment. In the case of payroll and invoices, the employee/vendor must return a check for the overpayment to the DOH/DDD Fiscal Office.

The DOH/DDD Fiscal Office maintains a log of money collected and submits to the DHS/MQD Finance Office on a quarterly basis to ensure proper crediting back to the federal government.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- ○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ◉ **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

a) The only waiver services that are not paid through an approved MMIS are environmental accessibility adaptations, certain specialized equipment that require unique pricing, vehicular modification, assistive technology, and consumer directed services.

b) & c) Environmental accessibility adaption, certain medical equipment requiring unique pricing, vehicular modification, and assistive technology:

Payment for these items is made by the DOH/DDD with 100% State funds. DOH/DDD sends copies of the purchase order and payment to DHS to support the federal FFP reimbursement. After verifying the payment, DHS/MQD transfers the FFP to DOH/DDD. The following identifies the steps taken to substantiate payment:

1) The DOH/DDD case manager authorizes services in the participant's services plan, sends hard copy notifications to the authorized provider for service type to be rendered with the participant's specific information.

2) After rendering the services, the provider submits an invoice for payment to the DOH/DDD case manager who confirms that the participant was Medicaid eligible at the time the work was performed or service delivered, and the invoice is within the prior authorized amount. If the invoice can be paid, the case manager authorizes the invoice for payment and sends the invoice to the DOH/DDD Fiscal Office.

3) The DOH/DDD Fiscal Office processes the invoice for payment following the authorized DAGS policies and procedures. DAGS will prepare and mail the check directly to the provider.

4) The DOH/DDD Fiscal Office generates a summary worksheet on a quarterly basis and submits it to DHS/MQD. The supporting documents (service authorization, invoice and purchase order) as proof of payment with 100% State funds are maintained with the DOH/DDD Fiscal Office and are available for DHS to review if necessary.

5) DOH/DDD reviews the summary worksheet prior to sending it to DHS/MQD to ensure there are no duplicate invoices.

6) DHS/MQD will send DOH/DDD a Bill of Collection for the non-federal portion for all transactions for the above-named services. DOH/DDD will voucher over the non-federal portion for all transactions for the above-named services. DOH/DDD will voucher over the non-federal share to DHS/MQD.

7) Payment to DOH/DDD is based on submission of a Bill of Collection by services which is based on the quarterly summary submitted by DOH/DDD as follows: a) reimbursement shall be allowed on invoices deemed payable; b) reimbursement shall be journal vouchered to DOH/DDD based on normal State fiscal timelines; c) reimbursement shall be determined on the fee that is notated on the paid invoices per supporting documentation submitted with the Bill of Collection.

8) Any services or work denied by DHS/MQD are returned to DOH/DDD for resolution.

9) A spreadsheet reflecting the paid invoices is attached to processed journal voucher and returned to DOH/DDD along with the original DOH/DDD worksheet for reconciliation purposes.

Consumer Directed (CD) Waiver Services: The DOH/DDD transfers the state match for CD services to DHS/MQD which transfers the FFP to DOH/DDD. The following identifies the steps taken to substantiate payment:

1) DOH/DDD case manager authorizes services in the participant's service plan and notifies the DOH/DDD CD specialist.

2) DOH/DDD specialist processes necessary payroll paperwork with the participant and sends the paperwork to the appropriate fiscal agent. DOH/DDD specialist coordinates meeting/training to participant/designated representative.

3) DOH/DDD specialist reviews all vouchers submitted by CD services participants to ensure the participant is Medicaid eligible and the services have been authorized.

○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

**b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☑ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☑ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

DHS/MQD through a contract with a limited fiscal agent pays for waiver services that use the Consumer Directed Option. The limited fiscal agent performs general payroll functions on behalf of the participants' employees.

The limited fiscal agent's services are primarily payroll activities such as withholding of applicable taxes. The limited fiscal agent, at the direction of DOH/DDD, generates special deduction checks (levies, child support, etc.). Oversight activities include the review of system summary reports as described in Appendix E and other quality activities conducted by DHS/MQD staff. DOH/DDD staff enters employee service data directly into the limited fiscal agent's system for processing of paychecks on the participant/employer's behalf. The DOH/DDD staff assures that human errors are kept at a minimum by conducting reviews at various stages: hours worked are verified against authorizations, check amount is validated, etc.

The DOH/DDD Fiscal Office submits a Bill of Collection to DHS/MQD for the State portion of the total payments made for the CD option. The charged amount is verified by a Summary Warrant Voucher report. The amount that is paid each month is recorded on the voucher log maintained by DHS/MQD and included in the CMS 64 report for each quarter.

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

**d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

**Answers provided in Appendix I-3-d indicate that you do not need to complete this section.**

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**

○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

◉ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

○ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** *Select one:*

◉ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

○ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- ( ) **This waiver is a part of a concurrent □1115/□1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The □1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [ ] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [x] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

  a) DOH/DDD
  b) Funds are directly expended by DOH as IGTs for Environmental Accessibility Adaptation, Specialized Medical Equipment & Supplies, Vehicular Modifications, Assistive Technology, and Personal Emergency Response System. DHS/MQD transfer FFP for all other waiver services processed through the fiscal agents.
- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

*Check each that applies:*

- [ ] **Appropriation of Local Government Revenues.**

  Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

  Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

*Check each that applies:*

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

SSI payments are used for room and board costs in adult foster homes, DD domiciliary homes, adult residential care homes, and expanded adult residential care homes.

All services rates that are billed by providers exclude room and board costs. The fiscal agent will only pay the rates that are loaded into HPMMIS and cannot override the rates to allow for any room or board costs.

When a participant receives respite, the participant's pro-rated SSI room and board costs that are normally paid by the participant to the routine caregiver are paid to the respite caregiver.

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

**a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

***Charges Associated with the Provision of Waiver Services*** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

*Specify:*

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

◉ **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

○ **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: ICF/IID**

| Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 | Col. 7 | Col. 8 |
|---|---|---|---|---|---|---|---|
| Year | Factor D | Factor D' | Total: D+D' | Factor G | Factor G' | Total: G+G' | Difference (Col 7 less Column4) |
| 1 | 42652.56 | 5649.62 | 48302.18 | 119424.79 | 4398.69 | 123823.48 | 75521.30 |
| 2 | 45559.37 | 5773.91 | 51333.28 | 122052.13 | 4495.46 | 126547.59 | 75214.31 |
| 3 | 49525.60 | 5900.93 | 55426.53 | 124737.28 | 4594.36 | 129331.64 | 73905.11 |
| 4 | 50892.68 | 6030.75 | 56923.43 | 127481.50 | 4695.44 | 132176.94 | 75253.51 |
| 5 | 52065.27 | 6163.43 | 58228.70 | 130286.09 | 4798.73 | 135084.82 | 76856.12 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

| Waiver Year | Total Unduplicated Number of Participants (from Item B-3-a) | Distribution of Unduplicated Participants by Level of Care (if applicable) |
|---|---|---|
| | | Level of Care: |
| | | ICF/IID |
| Year 1 | 2735 | 2735 |
| Year 2 | 2767 | 2767 |
| Year 3 | 2799 | 2799 |
| Year 4 | 2831 | 2831 |
| Year 5 | 2863 | 2863 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 9)

**b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay of 355 days is based on WY4 2014-2015 length of stay.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

**c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

**i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Estimates regarding the number of users and units per user were derived from an analysis of paid claims with start or end dates of services in state fiscal year 2015 (July 1, 2014 through June 30, 2015).

For services that are not being added or eliminated, the estimates generally assume the ratio of enrollees to users is constant for each service. So, each percentage increase in total enrollment leads to the same percentage increase in the number of users of a service. The number of units per user is assumed to remain constant the State does not anticipate changes in utilization patterns.

For services that are being added or eliminated, estimated units per user reflect the planned phase-in/ phase-out schedule, which is primarily based on participants' plan years. For example, for a service that is being added, the analysis is based on one-twelfth of the population having access to the new service for one month, one-twelfth of the population having access for two months, etc.

Changes to the fee schedule are being implemented in a similar fashion, with participants transitioning to the new rates based on their plan years. The analysis therefore employs a similar approach as described for units per user noted above.

Additional information with Waiver Amendment #02 includes further explanation about specific service estimates and average cost per unit:

PERSONAL ASSISTANCE/HABILITATION (PAB):
Personal Assistance/Habilitation (PAB) Levels 1 through 3 are phasing-out on a schedule approved with accordance with Waiver Amendment #01. The Personal Assistance/ Habilitation (PAB) service with no limits correspond to the 'new' service and rate while PAB Levels 1 through 3 reflect the 'legacy' service and rate. Participants are being transitioned to the new service over a two-year period based on when they receive a Supports Intensity Scale assessment and the date of their individual service plan. The transition begins in WY3 and only about one-half of the population will transition in this first year. The factors that influenced the estimates for PAB 'new' (no levels) reflect the impact of the transition plan. The WY5 number reflect the 'steady state' estimate when all participants have been transitioned to the 'new' service for the entire year. The estimates for waiver years 4 and 5 reflect the transition period during which individuals will have varying lengths of time receiving the 'new' service. For example, someone whose service plan year begins in the last month of the waiver year will receive only about one month of the new service, which will lower the average units per user per year figure.

SKILLED NURSING:
The user figures for WY3 were reduced to 128, the same as WY2 prior to the phase-out of the service. The increase in the average cost per unit reflects the results of the Burns & Associates rate study, which the State began implementing for all services in waiver year 2.

PRIVATE DUTY NURSING (RN AND LPN):
DOH/DDD completed a comprehensive review that included record reviews and some home visits to assess participants in person. Case files for approximately one-quarter of users of Skilled Nursing services were reviewed by State nurses who, based on the available documentation, determined whether the services were likely to be nursing services that would become the responsibility of the participant's health plan, or Private Duty Nursing, Nursing Respite, or Training and Consultation services covered through the waiver. The

resulting proportions were applied to the total number of current Skilled Nursing users to estimate the number of expected users of Private Duty Nursing.

The State then extracted the claims for the participants included in the case file review to determine the proportion of units that would convert to each of the new nurse-related services (which is not necessarily the same as the proportion of the users because current users are using differing amounts of services). The resulting proportions were applied to total Skilled Nursing claims to estimate the number units that would become Private Duty Nursing, which in turn was used to calculate the units per user figure.

The average cost per unit reflects the rates created by Burns & Associates.

TRAINING & CONSULTATION – OTHER:
This category includes behavior analysts; occupational, physical, and speech therapists; dieticians; psychologists; registered nurses; and licensed social workers. The changes to the Training and Consultation estimates for WY2 through WY5 relate to the phase-out of Skilled Nursing services. As part of the clinical case file review of existing Skilled Nursing users, the State estimated the proportion of users who could rely on services provided by direct support workers under the supervision of a registered nurse through the Training and Consultation service for nurse delegated activities. The findings from the case file review were used to allocate existing Skilled Nursing usage to Private Duty Nursing, Nursing Respite, Training and Consultation by a registered nurse, and nursing through the participant's health plan. In addition, a portion of the increase is due to the behavior analyst licensure law in Hawaii, which requires the T&C professional to provide more oversight and supervision of direct support workers when they are implementing formal behavior support plans. The increased estimates for the number of users and the average units per users are due to the creation of a new Training and Consultation service delivered by a registered nurse.

COMMUNITY LEARNING SERVICE (CLS):
The estimate for the number of users in WY3 is approximately half of those in WY4. Similar to the estimates for the 'new' Personal Assistance/ Habilitation service, the estimated number of users must be considered in concert with the estimated utilization for Personal Assistance/ Habilitation (PAB) Levels 1 through 3. A portion of existing PAB services are expected to transition to the new Community Learning Service-Individual (CLS-I). Participants are being transitioned to the new PAB and CLS-I services over a two-year period based on when they receive a Supports Intensity Scale assessment and the date of their individualized service plan. The transition begins in WY3 and only about one-half of the ultimate user population will transition in this first year. These estimates reflect the impact of the transition plan approved with Waiver Amendment #01. The WY5 number reflect the 'steady state' estimate when all participants have been transitioned to the CLS-I service for the entire year. The estimates for waiver years 4 and 5 reflect the transition period during which individuals will have varying lengths of time receiving the service. For example, someone whose service plan year begins in the last month of the waiver year will receive only about one month of the new service, which will lower the average units per user per year figure.

AVERAGE COST PER UNIT:
For all services with different rates for the Big Island (that is, all of the rates included in the Burns & Associates rate study excepting certain consumer-directed and 'interisland' services), the average cost per unit figures reflect a blended average of the Big Island and Other Island rates based on analysis of current utilization across the islands.

CHANGES TO WY1:
The changes to WY1 estimates represent minor corrections to the previous waiver amendment. Specifically:

- Personal Assistance/Habilitation Level 1 and Level 2 Average Units per User. A data entry error was made. The correction impacted the service expenditure subtotal and the total WY1 expenditure.

- Moved values from Training & Consultation row to Training & Consultation (Other) and removed the row titled "Training & Consultation". This did not change the service expenditure subtotal or the total WY1 expenditure. This change was done to differentiate the aggregate T&C services from the new rows added with Amendment #1 for T&C – EAA and T&C – AT and T&C – SMES.

- Where service rows had "0" Users and "0" Average Units per User, the State changed the Average Cost per Unit to "0.01" for consistency.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' projections are based on actual costs for WY4 2014-2015 ($5,430) then increased by 1.8% for WY5 and 2.2% each year of the waiver renewal, based on the CMS nursing home without Capital market Basket utilized by DHS/MQD to calculate the inflation factor for Hawaii PPS Rates. The state's estimate of D' costs does not include prescribed drugs for dual eligibles. Hawaii does not pay for any prescription drugs, including the copays for dual eligible members.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G projections are based on actual costs for WY4 2014-2015 ($114,788) then increased by 1.8% for WY5 and 2.2% each year of the waiver renewal, based on the CMS nursing home without Capital market Basket utilized by DHS/MQD to calculate the inflation factor for Hawaii PPS Rates.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' projections are based on actual costs for WY4 2014-2015 ($4,228) then increased by 1.8% for WY5 and 2.2% each year of the waiver renewal, based on the CMS nursing home without Capital market Basket utilized by DHS/MQD to calculate the inflation factor for Hawaii PPS Rates.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

| Waiver Services | |
|---|---|
| Adult Day Health (ADH) | |
| Discovery & Career Planning (DCP) | |
| Individual Employment Supports | |
| Personal Assistance/Habilitation (PAB) | |
| Residential Habilitation (ResHab) | |
| Respite | |
| Skilled Nursing | |
| Additional Residential Supports | |
| Assistive Technology | |
| Chore | |
| Community Learning Services (CLS) | |
| Environmental Accessibility Adaptations | |
| Non-Medical Transportation | |
| Personal Emergency Response System (PERS) | |
| Private Duty Nursing (PDN) | |
| Specialized Medical Equipment and Supplies | |
| Training and Consultation | |
| Vehicular Modifications | |
| Waiver Emergency Services | |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Health (ADH) Total:** | | | | | | **22343936.24** |
| Adult Day Health Level 1 | Day | 1042 | 185.20 | 66.56 | **12844642.30** | |
| Adult Day Health Level 2 | Day | 468 | 209.20 | 83.01 | **8127143.86** | |
| Adult Day Health Level 3 | Day | 58 | 201.60 | 117.35 | **1372150.08** | |
| Adult Day Health | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |
| **Discovery & Career Planning (DCP) Total:** | | | | | | **328536.72** |
| Discovery & Career Planning (DCP) | 15 min/unit | 30 | 1512.60 | 7.24 | **328536.72** | |
| **Individual Employment Supports Total:** | | | | | | **107546.16** |
| Individual Employment Supports | 15 min/unit | 11 | 741.80 | 13.18 | **107546.16** | |
| **Personal Assistance/Habilitation (PAB) Total:** | | | | | | **57169436.59** |
| Personal Assistance/Habilitation Level 1 | 15 min/unit | 1677 | 2735.60 | 6.23 | **28580755.48** | |
| Personal Assistance/Habilitation Level 2 | 15 min/unit | 621 | 3909.80 | 8.76 | **21269155.61** | |
| Personal Assistance/Habilitation Level 3 | 15 min/unit | 6 | 3880.20 | 9.78 | **227690.14** | |
| CD Personal Assistance/Habilitation | 15 min/unit | 541 | 4188.10 | 3.13 | **7091835.37** | |
| Personal Assistance/Habilitation | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |
| **Residential Habilitation (ResHab) Total:** | | | | | | **29986022.68** |
| Residential Habilitation (ResHab) | Day | 941 | 308.90 | 103.16 | **29986022.68** | |
| **Respite Total:** | | | | | | **2217201.29** |
| Respite Unit | 15 min/unit | 69 | 775.10 | 4.50 | **240668.55** | |
| Respite Daily | Day | 96 | 38.40 | 142.60 | **525680.64** | |
| | | | | | | |
| | | | **GRAND TOTAL:** | | | **116654742.64** |
| | | | **Total Estimated Unduplicated Participants:** | | | **2735** |
| | | | **Factor D (Divide total by number of participants):** | | | **42652.56** |
| | | | **Average Length of Stay on the Waiver:** | | | 355 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Respite Consumer Directed Unit | 15 min/unit | 197 | 1418.00 | 2.60 | **726299.60** | |
| Respite Consumer Directed Daily | Day | 175 | 37.00 | 111.90 | **724552.50** | |
| Respite RN | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |
| Respite LPN | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |
| **Skilled Nursing Total:** | | | | | | **3539907.00** |
| Skilled Nursing RN | 15 min/unit | 126 | 1708.60 | 12.50 | **2691045.00** | |
| Skilled Nursing LPN | 15 min/unit | 48 | 2021.10 | 8.75 | **848862.00** | |
| **Additional Residential Supports Total:** | | | | | | **0.00** |
| Additional Residential Supports | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |
| **Assistive Technology Total:** | | | | | | **25000.00** |
| Assistive Technology | Item | 5 | 5.00 | 1000.00 | **25000.00** | |
| **Chore Total:** | | | | | | **173349.51** |
| Chore | 15 min/unit | 27 | 1296.30 | 3.38 | **118300.34** | |
| Chore Consumer Directed | 15 min/unit | 19 | 1287.70 | 2.25 | **55049.18** | |
| **Community Learning Services (CLS) Total:** | | | | | | **0.00** |
| Community Learning Service- Individual | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |
| Community Learning Service- Group | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |
| **Environmental Accessibility Adaptations Total:** | | | | | | **40000.00** |
| Environmental Accessibility Adaptations | Service | 1 | 1.00 | 40000.00 | **40000.00** | |
| **Non-Medical Transportation Total:** | | | | | | **87543.63** |
| Transportation Mile | Mile | 13 | 2976.90 | 1.89 | **73142.43** | |
| Transportation Trips | Trip | 33 | 218.20 | 2.00 | **14401.20** | |
| **Personal Emergency Response System (PERS) Total:** | | | | | | **2077.41** |
| Personal Emergency Response System (PERS) Service | Service | 1 | 3.00 | 21.67 | **65.01** | |

| | |
|---|---|
| **GRAND TOTAL:** | **116654742.64** |
| **Total Estimated Unduplicated Participants:** | **2735** |
| **Factor D (Divide total by number of participants):** | **42652.56** |
| **Average Length of Stay on the Waiver:** | 355 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Personal Emergency Response System (PERS) Monthly | Month | 6 | 7.80 | 43.00 | 2012.40 | |
| **Private Duty Nursing (PDN) Total:** | | | | | | 0.00 |
| Private Duty Nursing RN | 15 min/unit | 0 | 0.00 | 0.01 | 0.00 | |
| Private Duty Nursing LPN | 15 min/unit | 0 | 0.00 | 0.01 | 0.00 | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | 1174.00 |
| Specialized Medical Equipment and Supplies | Item | 2 | 1.00 | 587.00 | 1174.00 | |
| **Training and Consultation Total:** | | | | | | 335977.15 |
| Training & Consultation-Other | Hour | 84 | 44.60 | 89.68 | 335977.15 | |
| T&C- EAA Assessment & Training | Hour | 0 | 0.00 | 0.01 | 0.00 | |
| T&C- SMES Assessment & Training | Hour | 0 | 0.00 | 0.01 | 0.00 | |
| T&C- AT Assessment & Training | Hour | 0 | 0.00 | 0.01 | 0.00 | |
| **Vehicular Modifications Total:** | | | | | | 25000.00 |
| Vehicular Modifications | Service | 1 | 1.00 | 25000.00 | 25000.00 | |
| Vehicular Modification Repair | Service | 0 | 0.00 | 0.01 | 0.00 | |
| **Waiver Emergency Services Total:** | | | | | | 272034.24 |
| Out of Home Stabilization | Day | 10 | 53.80 | 499.23 | 268585.74 | |
| Emergency Outreach | Hour | 33 | 3.80 | 27.50 | 3448.50 | |
| | | | | **GRAND TOTAL:** | | 116654742.64 |
| | | | | **Total Estimated Unduplicated Participants:** | | 2735 |
| | | | | **Factor D (Divide total by number of participants):** | | 42652.56 |
| | | | | **Average Length of Stay on the Waiver:** | | 355 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Health (ADH) Total:** | | | | | | **21533660.89** |
| Adult Day Health Level 1 | Day | 1054 | 92.60 | 66.56 | **6496282.62** | |
| Adult Day Health Level 2 | Day | 473 | 104.60 | 83.01 | **4106986.16** | |
| Adult Day Health Level 3 | Day | 59 | 100.80 | 117.35 | **697903.92** | |
| Adult Day Health | 15 min/unit | 1586 | 2054.70 | 3.14 | **10232488.19** | |
| **Discovery & Career Planning (DCP) Total:** | | | | | | **451511.10** |
| Discovery & Career Planning (DCP) | 15 min/unit | 30 | 1512.60 | 9.95 | **451511.10** | |
| **Individual Employment Supports Total:** | | | | | | **109133.62** |
| Individual Employment Supports | 15 min/unit | 12 | 741.80 | 12.26 | **109133.62** | |
| **Personal Assistance/Habilitation (PAB) Total:** | | | | | | **58420632.25** |
| Personal Assistance/Habilitation Level 1 | 15 min/unit | 1697 | 2735.60 | 6.23 | **28921611.24** | |
| Personal Assistance/Habilitation Level 2 | 15 min/unit | 628 | 3735.50 | 8.76 | **20550031.44** | |
| Personal Assistance/Habilitation Level 3 | 15 min/unit | 6 | 3880.20 | 9.78 | **227690.14** | |
| CD Personal Assistance/Habilitation | 15 min/unit | 548 | 4188.10 | 3.80 | **8721299.44** | |
| Personal Assistance/Habilitation | 15 min/unit | 0 | 0.00 | 8.30 | **0.00** | |
| **Residential Habilitation (ResHab) Total:** | | | | | | **33418432.99** |
| Residential Habilitation (ResHab) | Day | 952 | 308.90 | 113.64 | **33418432.99** | |
| **Respite Total:** | | | | | | **3231203.14** |
| Respite Unit | 15 min/unit | 167 | 1127.90 | 5.22 | **983235.55** | |
| Respite Daily | Day | 97 | 19.20 | 142.60 | **265578.24** | |
| Respite Consumer Directed Unit | 15 min/unit | 376 | 1377.50 | 3.12 | **1615972.80** | |
| Respite Consumer Directed Daily | Day | 177 | 18.50 | 111.90 | **366416.55** | |
| Respite RN | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |

| | |
|---|---|
| **GRAND TOTAL:** | **126062778.10** |
| **Total Estimated Unduplicated Participants:** | **2767** |
| **Factor D (Divide total by number of participants):** | **45559.37** |
| **Average Length of Stay on the Waiver:** | 355 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Respite LPN | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |
| **Skilled Nursing Total:** | | | | | | **4748138.90** |
| Skilled Nursing RN | 15 min/unit | 128 | 1708.60 | 16.88 | **3691669.50** | |
| Skilled Nursing LPN | 15 min/unit | 48 | 2021.10 | 10.89 | **1056469.39** | |
| **Additional Residential Supports Total:** | | | | | | **1547892.00** |
| Additional Residential Supports | 15 min/unit | 95 | 2920.00 | 5.58 | **1547892.00** | |
| **Assistive Technology Total:** | | | | | | **25000.00** |
| Assistive Technology | Item | 5 | 5.00 | 1000.00 | **25000.00** | |
| **Chore Total:** | | | | | | **237301.33** |
| Chore | 15 min/unit | 27 | 1296.30 | 4.62 | **161700.46** | |
| Chore Consumer Directed | 15 min/unit | 19 | 1287.70 | 3.09 | **75600.87** | |
| **Community Learning Services (CLS) Total:** | | | | | | **1461600.50** |
| Community Learning Service- Individual | 15 min/unit | 0 | 0.00 | 8.37 | **0.00** | |
| Community Learning Service- Group | 15 min/unit | 1586 | 190.80 | 4.83 | **1461600.50** | |
| **Environmental Accessibility Adaptations Total:** | | | | | | **110000.00** |
| Environmental Accessibility Adaptations | Service | 2 | 1.00 | 55000.00 | **110000.00** | |
| **Non-Medical Transportation Total:** | | | | | | **88605.18** |
| Transportation Mile | Mile | 14 | 2976.90 | 1.77 | **73767.58** | |
| Transportation Trips | Trip | 34 | 218.20 | 2.00 | **14837.60** | |
| **Personal Emergency Response System (PERS) Total:** | | | | | | **2077.41** |
| Personal Emergency Response System (PERS) Service | Service | 1 | 3.00 | 21.67 | **65.01** | |
| Personal Emergency Response System (PERS) Monthly | Month | 6 | 7.80 | 43.00 | **2012.40** | |
| **Private Duty Nursing (PDN) Total:** | | | | | | **0.00** |
| Private Duty Nursing RN | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |

| | |
|---|---|
| **GRAND TOTAL:** | **126062778.10** |
| **Total Estimated Unduplicated Participants:** | **2767** |
| **Factor D (Divide total by number of participants):** | **45559.37** |
| **Average Length of Stay on the Waiver:** | 355 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Private Duty Nursing LPN | 15 min/unit | 0 | 0.00 | 0.01 | 0.00 | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | 1174.00 |
| Specialized Medical Equipment and Supplies | Item | 2 | 1.00 | 587.00 | 1174.00 | |
| **Training and Consultation Total:** | | | | | | 332276.05 |
| Training & Consultation-Other | Hour | 81 | 44.60 | 89.02 | 321593.65 | |
| T&C- EAA Assessment & Training | Hour | 2 | 25.00 | 89.02 | 4451.00 | |
| T&C- SMES Assessment & Training | Hour | 2 | 10.00 | 89.02 | 1780.40 | |
| T&C- AT Assessment & Training | Hour | 5 | 10.00 | 89.02 | 4451.00 | |
| **Vehicular Modifications Total:** | | | | | | 72000.00 |
| Vehicular Modifications | Service | 2 | 1.00 | 36000.00 | 72000.00 | |
| Vehicular Modification Repair | Service | 0 | 0.00 | 0.01 | 0.00 | |
| **Waiver Emergency Services Total:** | | | | | | 272138.74 |
| Out of Home Stabilization | Day | 10 | 53.80 | 499.23 | 268585.74 | |
| Emergency Outreach | Hour | 34 | 3.80 | 27.50 | 3553.00 | |

| | |
|---|---|
| GRAND TOTAL: | 126062778.10 |
| Total Estimated Unduplicated Participants: | 2767 |
| Factor D (Divide total by number of participants): | 45559.37 |
| Average Length of Stay on the Waiver: | 355 |

# Appendix J: Cost Neutrality Demonstration

## J-2: Derivation of Estimates (7 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Health (ADH) Total:** | | | | | | 22124887.88 |

| | |
|---|---|
| GRAND TOTAL: | 138622147.59 |
| Total Estimated Unduplicated Participants: | 2799 |
| Factor D (Divide total by number of participants): | 49525.60 |
| Average Length of Stay on the Waiver: | 355 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Adult Day Health Level 1 | Day | 0 | 0.00 | 0.01 | **0.00** | |
| Adult Day Health Level 2 | Day | 0 | 0.00 | 0.01 | **0.00** | |
| Adult Day Health Level 3 | Day | 0 | 0.00 | 0.01 | **0.00** | |
| Adult Day Health | 15 min/unit | 1604 | 4068.90 | 3.39 | **22124887.88** | |
| **Discovery & Career Planning (DCP) Total:** | | | | | | **585194.69** |
| Discovery & Career Planning (DCP) | 15 min/unit | 31 | 1512.60 | 12.48 | **585194.69** | |
| **Individual Employment Supports Total:** | | | | | | **100855.13** |
| Individual Employment Supports | 15 min/unit | 12 | 741.80 | 11.33 | **100855.13** | |
| **Personal Assistance/Habilitation (PAB) Total:** | | | | | | **61537128.66** |
| Personal Assistance/Habilitation Level 1 | 15 min/unit | 1717 | 2051.70 | 6.23 | **21946850.25** | |
| Personal Assistance/Habilitation Level 2 | 15 min/unit | 635 | 2770.70 | 8.76 | **15412295.82** | |
| Personal Assistance/Habilitation Level 3 | 15 min/unit | 6 | 2910.10 | 9.78 | **170764.67** | |
| CD Personal Assistance/Habilitation | 15 min/unit | 554 | 4188.10 | 4.45 | **10324922.93** | |
| Personal Assistance/Habilitation | 15 min/unit | 1179 | 1375.00 | 8.44 | **13682295.00** | |
| **Residential Habilitation (ResHab) Total:** | | | | | | **36850670.32** |
| Residential Habilitation (ResHab) | Day | 963 | 308.90 | 123.88 | **36850670.32** | |
| **Respite Total:** | | | | | | **5482400.39** |
| Respite Unit | 15 min/unit | 197 | 2047.60 | 4.67 | **1883771.52** | |
| Respite Daily | Day | 28 | 19.20 | 142.60 | **76661.76** | |
| Respite Consumer Directed Unit | 15 min/unit | 380 | 2004.90 | 3.30 | **2514144.60** | |
| Respite Consumer Directed Daily | Day | 0 | 0.00 | 0.01 | **0.00** | |
| Respite RN | 15 min/unit | 47 | 978.70 | 18.19 | **836719.99** | |
| Respite LPN | 15 min/unit | 23 | 716.00 | 10.39 | **171102.52** | |

| | |
|---|---|
| **GRAND TOTAL:** | **138622147.59** |
| **Total Estimated Unduplicated Participants:** | **2799** |
| **Factor D (Divide total by number of participants):** | **49525.60** |
| **Average Length of Stay on the Waiver:** | 355 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Skilled Nursing Total:** | | | | | | **2959009.52** |
| Skilled Nursing RN | 15 min/unit | 128 | 854.30 | 21.20 | **2318228.48** | |
| Skilled Nursing LPN | 15 min/unit | 49 | 1010.60 | 12.94 | **640781.04** | |
| **Additional Residential Supports Total:** | | | | | | **1564185.60** |
| Additional Residential Supports | 15 min/unit | 96 | 2920.00 | 5.58 | **1564185.60** | |
| **Assistive Technology Total:** | | | | | | **25000.00** |
| Assistive Technology | Item | 5 | 5.00 | 1000.00 | **25000.00** | |
| **Chore Total:** | | | | | | **305582.79** |
| Chore | 15 min/unit | 28 | 1296.30 | 5.77 | **209430.23** | |
| Chore Consumer Directed | 15 min/unit | 19 | 1287.70 | 3.93 | **96152.56** | |
| **Community Learning Services (CLS) Total:** | | | | | | **4066772.54** |
| Community Learning Service- Individual | 15 min/unit | 1179 | 142.10 | 8.57 | **1435782.66** | |
| Community Learning Service- Group | 15 min/unit | 1604 | 339.60 | 4.83 | **2630989.87** | |
| **Environmental Accessibility Adaptations Total:** | | | | | | **110000.00** |
| Environmental Accessibility Adaptations | Service | 2 | 1.00 | 55000.00 | **110000.00** | |
| **Non-Medical Transportation Total:** | | | | | | **113695.96** |
| Transportation Mile | Mile | 14 | 2976.90 | 1.66 | **69183.16** | |
| Transportation Trips | Trip | 34 | 218.20 | 6.00 | **44512.80** | |
| **Personal Emergency Response System (PERS) Total:** | | | | | | **2077.41** |
| Personal Emergency Response System (PERS) Service | Service | 1 | 3.00 | 21.67 | **65.01** | |
| Personal Emergency Response System (PERS) Monthly | Month | 6 | 7.80 | 43.00 | **2012.40** | |
| **Private Duty Nursing (PDN) Total:** | | | | | | **756364.28** |
| Private Duty Nursing RN | 15 min/unit | 35 | 664.50 | 19.95 | **463987.12** | |
| Private Duty Nursing LPN | 15 min/unit | | 1086.50 | 11.70 | **292377.15** | |

| | |
|---|---|
| **GRAND TOTAL:** | **138622147.59** |
| **Total Estimated Unduplicated Participants:** | **2799** |
| **Factor D (Divide total by number of participants):** | **49525.60** |
| **Average Length of Stay on the Waiver:** | 355 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | | 23 | | | | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | **1174.00** |
| Specialized Medical Equipment and Supplies | Item | 2 | 1.00 | 587.00 | **1174.00** | |
| **Training and Consultation Total:** | | | | | | **1646151.12** |
| Training & Consultation-Other | Hour | 202 | 73.50 | 110.16 | **1635545.52** | |
| T&C- EAA Assessment & Training | Hour | 2 | 25.00 | 88.38 | **4419.00** | |
| T&C- SMES Assessment & Training | Hour | 2 | 10.00 | 88.38 | **1767.60** | |
| T&C- AT Assessment & Training | Hour | 5 | 10.00 | 88.38 | **4419.00** | |
| **Vehicular Modifications Total:** | | | | | | **92000.00** |
| Vehicular Modifications | Service | 2 | 1.00 | 36000.00 | **72000.00** | |
| Vehicular Modification Repair | Service | 2 | 1.00 | 10000.00 | **20000.00** | |
| **Waiver Emergency Services Total:** | | | | | | **298997.31** |
| Out of Home Stabilization | Day | 11 | 53.80 | 499.23 | **295444.31** | |
| Emergency Outreach | Hour | 34 | 3.80 | 27.50 | **3553.00** | |
| | | | | **GRAND TOTAL:** | | **138622147.59** |
| | | | | **Total Estimated Unduplicated Participants:** | | **2799** |
| | | | | **Factor D (Divide total by number of participants):** | | **49525.60** |
| | | | | **Average Length of Stay on the Waiver:** | | 355 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Health (ADH) Total:** | | | | | | **22478507.80** |
| | | | | **GRAND TOTAL:** | | **144077190.22** |
| | | | | **Total Estimated Unduplicated Participants:** | | **2831** |
| | | | | **Factor D (Divide total by number of participants):** | | **50892.68** |
| | | | | **Average Length of Stay on the Waiver:** | | 355 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Adult Day Health Level 1 | Day | 0 | 0.00 | 0.01 | **0.00** | |
| Adult Day Health Level 2 | Day | 0 | 0.00 | 0.01 | **0.00** | |
| Adult Day Health Level 3 | Day | 0 | 0.00 | 0.01 | **0.00** | |
| Adult Day Health | 15 min/unit | 1623 | 4049.70 | 3.42 | **22478507.80** | |
| **Discovery & Career Planning (DCP) Total:** | | | | | | **585194.69** |
| Discovery & Career Planning (DCP) | 15 min/unit | 31 | 1512.60 | 12.48 | **585194.69** | |
| **Individual Employment Supports Total:** | | | | | | **100855.13** |
| Individual Employment Supports | 15 min/unit | 12 | 741.80 | 11.33 | **100855.13** | |
| **Personal Assistance/Habilitation (PAB) Total:** | | | | | | **64234085.54** |
| Personal Assistance/Habilitation Level 1 | 15 min/unit | 868 | 1367.80 | 6.23 | **7396569.99** | |
| Personal Assistance/Habilitation Level 2 | 15 min/unit | 322 | 1824.20 | 8.76 | **5145557.42** | |
| Personal Assistance/Habilitation Level 3 | 15 min/unit | 3 | 1940.10 | 9.78 | **56922.53** | |
| CD Personal Assistance/Habilitation | 15 min/unit | 560 | 4188.10 | 4.44 | **10413291.84** | |
| Personal Assistance/Habilitation | 15 min/unit | 2385 | 2062.50 | 8.38 | **41221743.75** | |
| **Residential Habilitation (ResHab) Total:** | | | | | | **37202402.39** |
| Residential Habilitation (ResHab) | Day | 974 | 308.90 | 123.65 | **37202402.39** | |
| **Respite Total:** | | | | | | **6404185.99** |
| Respite Unit | 15 min/unit | 172 | 1931.90 | 5.26 | **1747828.57** | |
| Respite Daily | Day | 28 | 19.20 | 142.60 | **76661.76** | |
| Respite Consumer Directed Unit | 15 min/unit | 385 | 2003.80 | 3.29 | **2538113.27** | |
| Respite Consumer Directed Daily | Day | 0 | 0.00 | 0.01 | **0.00** | |
| Respite RN | 15 min/unit | 48 | 1946.30 | 18.19 | **1699353.46** | |
| Respite LPN | 15 min/unit | 23 | 1432.10 | 10.39 | **342228.94** | |

| | |
|---|---|
| **GRAND TOTAL:** | **144077190.22** |
| **Total Estimated Unduplicated Participants:** | **2831** |
| **Factor D (Divide total by number of participants):** | **50892.68** |
| **Average Length of Stay on the Waiver:** | 355 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Skilled Nursing Total:** | | | | | | **0.00** |
| Skilled Nursing RN | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |
| Skilled Nursing LPN | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |
| **Additional Residential Supports Total:** | | | | | | **1580479.20** |
| Additional Residential Supports | 15 min/unit | 97 | 2920.00 | 5.58 | **1580479.20** | |
| **Assistive Technology Total:** | | | | | | **25000.00** |
| Assistive Technology | Item | 5 | 5.00 | 1000.00 | **25000.00** | |
| **Chore Total:** | | | | | | **305582.79** |
| Chore | 15 min/unit | 28 | 1296.30 | 5.77 | **209430.23** | |
| Chore Consumer Directed | 15 min/unit | 19 | 1287.70 | 3.93 | **96152.56** | |
| **Community Learning Services (CLS) Total:** | | | | | | **7249563.63** |
| Community Learning Service- Individual | 15 min/unit | 2385 | 213.10 | 8.48 | **4309904.88** | |
| Community Learning Service- Group | 15 min/unit | 1623 | 375.00 | 4.83 | **2939658.75** | |
| **Environmental Accessibility Adaptations Total:** | | | | | | **110000.00** |
| Environmental Accessibility Adaptations | Service | 2 | 1.00 | 55000.00 | **110000.00** | |
| **Non-Medical Transportation Total:** | | | | | | **113695.96** |
| Transportation Mile | Mile | 14 | 2976.90 | 1.66 | **69183.16** | |
| Transportation Trips | Trip | 34 | 218.20 | 6.00 | **44512.80** | |
| **Personal Emergency Response System (PERS) Total:** | | | | | | **2077.41** |
| Personal Emergency Response System (PERS) Service | Service | 1 | 3.00 | 21.67 | **65.01** | |
| Personal Emergency Response System (PERS) Monthly | Month | 6 | 7.80 | 43.00 | **2012.40** | |
| **Private Duty Nursing (PDN) Total:** | | | | | | **1527104.52** |
| Private Duty Nursing RN | 15 min/unit | 36 | 1312.10 | 19.95 | **942350.22** | |
| Private Duty Nursing LPN | 15 min/unit | | 2173.00 | 11.70 | **584754.30** | |

| | |
|---|---|
| **GRAND TOTAL:** | **144077190.22** |
| **Total Estimated Unduplicated Participants:** | **2831** |
| **Factor D (Divide total by number of participants):** | **50892.68** |
| **Average Length of Stay on the Waiver:** | 355 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | | 23 | | | | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | **1174.00** |
| Specialized Medical Equipment and Supplies | Item | 2 | 1.00 | 587.00 | **1174.00** | |
| **Training and Consultation Total:** | | | | | | **1766283.86** |
| Training & Consultation-Other | Hour | 218 | 72.10 | 111.70 | **1755678.26** | |
| T&C- EAA Assessment & Training | Hour | 2 | 25.00 | 88.38 | **4419.00** | |
| T&C- SMES Assessment & Training | Hour | 2 | 10.00 | 88.38 | **1767.60** | |
| T&C- AT Assessment & Training | Hour | 5 | 10.00 | 88.38 | **4419.00** | |
| **Vehicular Modifications Total:** | | | | | | **92000.00** |
| Vehicular Modifications | Service | 2 | 1.00 | 36000.00 | **72000.00** | |
| Vehicular Modification Repair | Service | 2 | 1.00 | 10000.00 | **20000.00** | |
| **Waiver Emergency Services Total:** | | | | | | **298997.31** |
| Out of Home Stabilization | Day | 11 | 53.80 | 499.23 | **295444.31** | |
| Emergency Outreach | Hour | 34 | 3.80 | 27.50 | **3553.00** | |
| | | | | **GRAND TOTAL:** | | **144077190.22** |
| | | | | **Total Estimated Unduplicated Participants:** | | **2831** |
| | | | | **Factor D (Divide total by number of participants):** | | **50892.68** |
| | | | | **Average Length of Stay on the Waiver:** | | 355 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (9 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Health (ADH) Total:** | | | | | | **22865611.89** |
| | | | | **GRAND TOTAL:** | | **149062858.91** |
| | | | | **Total Estimated Unduplicated Participants:** | | **2863** |
| | | | | **Factor D (Divide total by number of participants):** | | **52065.27** |
| | | | | **Average Length of Stay on the Waiver:** | | 355 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Adult Day Health Level 1 | Day | 0 | 0.00 | 0.01 | **0.00** | |
| Adult Day Health Level 2 | Day | 0 | 0.00 | 0.01 | **0.00** | |
| Adult Day Health Level 3 | Day | 0 | 0.00 | 0.01 | **0.00** | |
| Adult Day Health | 15 min/unit | 1642 | 4048.10 | 3.44 | **22865611.89** | |
| **Discovery & Career Planning (DCP) Total:** | | | | | | **585194.69** |
| Discovery & Career Planning (DCP) | 15 min/unit | 31 | 1512.60 | 12.48 | **585194.69** | |
| **Individual Employment Supports Total:** | | | | | | **100855.13** |
| Individual Employment Supports | 15 min/unit | 12 | 741.80 | 11.33 | **100855.13** | |
| **Personal Assistance/Habilitation (PAB) Total:** | | | | | | **66146834.93** |
| Personal Assistance/Habilitation Level 1 | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |
| Personal Assistance/Habilitation Level 2 | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |
| Personal Assistance/Habilitation Level 3 | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |
| CD Personal Assistance/Habilitation | 15 min/unit | 567 | 4188.10 | 4.42 | **10495964.93** | |
| Personal Assistance/Habilitation | 15 min/unit | 2412 | 2750.00 | 8.39 | **55650870.00** | |
| **Residential Habilitation (ResHab) Total:** | | | | | | **37552571.43** |
| Residential Habilitation (ResHab) | Day | 985 | 308.90 | 123.42 | **37552571.43** | |
| **Respite Total:** | | | | | | **6446616.49** |
| Respite Unit | 15 min/unit | 174 | 1929.90 | 5.23 | **1756247.60** | |
| Respite Daily | Day | 29 | 19.20 | 142.60 | **79399.68** | |
| Respite Consumer Directed Unit | 15 min/unit | 389 | 2004.20 | 3.27 | **2549402.53** | |
| Respite Consumer Directed Daily | Day | 0 | 0.00 | 0.01 | **0.00** | |
| Respite RN | 15 min/unit | 48 | 1961.20 | 18.19 | **1712362.94** | |
| Respite LPN | 15 min/unit | 24 | 1400.40 | 10.39 | **349203.74** | |

| | |
|---|---|
| **GRAND TOTAL:** | **149062858.91** |
| **Total Estimated Unduplicated Participants:** | **2863** |
| **Factor D (Divide total by number of participants):** | **52065.27** |
| **Average Length of Stay on the Waiver:** | 355 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Skilled Nursing Total:** | | | | | | **0.00** |
| Skilled Nursing RN | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |
| Skilled Nursing LPN | 15 min/unit | 0 | 0.00 | 0.01 | **0.00** | |
| **Additional Residential Supports Total:** | | | | | | **1613066.40** |
| Additional Residential Supports | 15 min/unit | 99 | 2920.00 | 5.58 | **1613066.40** | |
| **Assistive Technology Total:** | | | | | | **25000.00** |
| Assistive Technology | Item | 5 | 5.00 | 1000.00 | **25000.00** | |
| **Chore Total:** | | | | | | **305582.79** |
| Chore | 15 min/unit | 28 | 1296.30 | 5.77 | **209430.23** | |
| Chore Consumer Directed | 15 min/unit | 19 | 1287.70 | 3.93 | **96152.56** | |
| **Community Learning Services (CLS) Total:** | | | | | | **9385066.54** |
| Community Learning Service- Individual | 15 min/unit | 2412 | 284.10 | 8.49 | **5817765.71** | |
| Community Learning Service- Group | 15 min/unit | 1642 | 449.80 | 4.83 | **3567300.83** | |
| **Environmental Accessibility Adaptations Total:** | | | | | | **110000.00** |
| Environmental Accessibility Adaptations | Service | 2 | 1.00 | 55000.00 | **110000.00** | |
| **Non-Medical Transportation Total:** | | | | | | **115005.16** |
| Transportation Mile | Mile | 14 | 2976.90 | 1.66 | **69183.16** | |
| Transportation Trips | Trip | 35 | 218.20 | 6.00 | **45822.00** | |
| **Personal Emergency Response System (PERS) Total:** | | | | | | **2077.41** |
| Personal Emergency Response System (PERS) Service | Service | 1 | 3.00 | 21.67 | **65.01** | |
| Personal Emergency Response System (PERS) Monthly | Month | 6 | 7.80 | 43.00 | **2012.40** | |
| **Private Duty Nursing (PDN) Total:** | | | | | | **1546204.14** |
| Private Duty Nursing RN | 15 min/unit | 36 | 1322.10 | 19.95 | **949532.22** | |
| Private Duty Nursing LPN | 15 min/unit | | 2124.90 | 11.70 | **596671.92** | |

| | |
|---|---|
| **GRAND TOTAL:** | **149062858.91** |
| **Total Estimated Unduplicated Participants:** | **2863** |
| **Factor D (Divide total by number of participants):** | **52065.27** |
| **Average Length of Stay on the Waiver:** | 355 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| | | 24 | | | | |
| **Specialized Medical Equipment and Supplies Total:** | | | | | | **1174.00** |
| Specialized Medical Equipment and Supplies | Item | 2 | 1.00 | 587.00 | **1174.00** | |
| **Training and Consultation Total:** | | | | | | **1870896.11** |
| Training & Consultation-Other | Hour | 233 | 70.40 | 113.41 | **1860286.91** | |
| T&C- EAA Assessment & Training | Hour | 2 | 25.00 | 88.41 | **4420.50** | |
| T&C- SMES Assessment & Training | Hour | 2 | 10.00 | 88.41 | **1768.20** | |
| T&C- AT Assessment & Training | Hour | 5 | 10.00 | 88.41 | **4420.50** | |
| **Vehicular Modifications Total:** | | | | | | **92000.00** |
| Vehicular Modifications | Service | 2 | 1.00 | 36000.00 | **72000.00** | |
| Vehicular Modification Repair | Service | 2 | 1.00 | 10000.00 | **20000.00** | |
| **Waiver Emergency Services Total:** | | | | | | **299101.81** |
| Out of Home Stabilization | Day | 11 | 53.80 | 499.23 | **295444.31** | |
| Emergency Outreach | Hour | 35 | 3.80 | 27.50 | **3657.50** | |

| | |
|---|---|
| **GRAND TOTAL:** | **149062858.91** |
| **Total Estimated Unduplicated Participants:** | **2863** |
| **Factor D (Divide total by number of participants):** | **52065.27** |
| **Average Length of Stay on the Waiver:** | 355 |